U.S. Department of Transportation
United States Coast Guard

Commandant (G-PC-4)
United States Coast Guard

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COMDTINST M12810.2

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COMMANDANT INSTRUCTION M12810.2

Subj: Workers' Compensation Policies and Procedures

Ref: (a) 20 CFR, Part 10
(b) 5 CFR 339.301
(c) Federal Personnel Manual, Chapter 810
(d) Federal Personnel Manual, Chapter 339
(e) Federal Personnel Manual Supplement 870-1
(f) Federal Personnel Manual Supplement 890-1
(g) Training for Compensation Specialists Resource Books

1. PURPOSE. This Instruction establishes Coast Guard policy and procedures for administering the Federal Employees' Compensation Act (FECA) which provides compensation benefits to civilian employees of the United States for disability due to personal injury or disease sustained while in the performance of duty.

2. DIRECTIVE AFFECTED. COMDTINST 12810.1 (series), Workers' Compensation Forms and Procedures, dated 26 January 1988, is cancelled.

3. ACTION. Area and district commanders, commanders of maintenance and logistics commands, unit commanding officer and Commander, Coast Guard Activities Europe, shall comply with the provisions of this Instruction.

4. FORMS AVAILABILITY. Forms used for processing compensation claims are available from the Superintendent of Documents, U.S. Government Printing Office. Form titles and stock numbers are shown in enclosure (1) to this Instruction. In

DISTRIBUTION—SDL No. 129

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A																										
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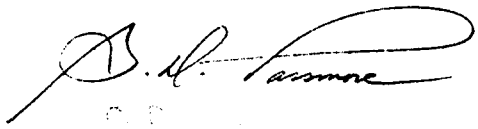
4. (cont'd) addition, these forms have been included as enclosures (2) through (15) to this Instruction. They may be duplicated as needed; however, they must be duplicated on the same color paper as the original.



U.S. COAST GUARD
WORKERS' COMPENSATION POLICIES AND PROCEDURES

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Chapter 4. (cont'd)

CHAPTER 1. BACKGROUND AND COVERAGE

A. Background.

1. The Federal Employees' Compensation Act (FECA) provides compensation benefits to civilian employees for disability due to personal injury or disease sustained while in the performance of duty. The FECA also provides for the payment of benefits to dependents if a work-related injury or disease causes an employee's death.

2. The FECA program is administered by the Department of Labor, Office of Workers' Compensation Programs (OWCP). (See enclosure (16) of this Instruction for addresses and territorial jurisdictions for all OWCP district offices.) It is financed by the Employee's Compensation Fund which consists of funds appropriated by Congress directly or indirectly through a chargeback system to Federal agencies.

3. Benefits provided under the FECA constitute the sole remedy against the United States for work-related injury or death. A Federal employee or surviving dependent is not entitled to sue the United States or recover damages for such injury or death under any other statute.

B. Coverage. This Instruction applies to all appropriated fund civilian employees of the Coast Guard, including temporary employees and Coast Guard auxiliarists. Contract employees, volunteers, and loaned employees are covered as determined by Department of Labor, OWCP, on a case-by-case basis once a claim is filed.

C. Penalties.

1. Any person who knowingly makes or knowingly certifies to any false statement, misrepresentation, concealment of fact, or any other act of fraud with respect to a claim under the FECA or who knowingly accepts compensation to which that person is not entitled, is subject to criminal prosecution and may be punished by a fine of not more than $10,000, or by imprisonment up to 5 years, or both.

2. Any person responsible for making reports in connection with an injury who willfully fails, neglects, or refuses to make a report of injury; induces, compels, or directs an injured employee to forego filing a claim; or willfully retains any notice, report, or paper required; or files a false report, shall be fined not more than $500 or imprisoned not more than 1 year, or both.

1. D. Appeal Rights. If an employee or an employee's survivors disagree with a final determination of the OWCP claim, a reconsideration or review may be requested. The employee or survivor also has the right to a hearing before the OWCP and the right to appeal any decision to the Employees' Compensation Appeals Board, a separate entity in the U.S. Department of Labor.

E. Restoration Rights. Employees who recover within 1 year of beginning compensation or who are considered physically disabled have mandatory restoration rights to the position last held or its equivalent, regardless of whether they are terminated. If full recovery occurs after 1 year, the employee is entitled to priority consideration with the Office of Personnel Management (OPM) provided that application is made within 30 days of the date compensation ceases.

F. Third Party.

1. In the event that an injury is caused by a person or object under circumstances which indicate there is a legal liability on a party other than the U.S. Government to pay the damages, the Federal Government has a subrogation interest (i.e., the right to recover any payments it makes should the employee collect money from another source). The OWCP will collect such payments from the employee and, in turn, will credit the Coast Guard's account through the chargeback process.

2. While a claim is pending against the third party, OWCP will provide medical and compensation benefits authorized by the FECA.

3. In the event of recovery from the third party, the employee must first pay outstanding legal fees and costs, and then may retain 20 percent of the amount remaining. Generally, the full amount or as much as possible of the medical and compensation payments made at the time of settlement must then be refunded. Any money remaining may be retained by the employee, but is credited against possible future expenses by the OWCP.

CHAPTER 2. DEFINITIONS

A. Chargeback. The mechanism by which the costs of compensation for work-related injuries and deaths are assigned to employing agencies.

B. Continuation of Pay (COP). The continuation of an employee's regular pay by the Coast Guard without charge to sick or annual leave. COP is only given in traumatic injury cases (not occupational disease cases) for a maximum of 45 calendar days. In order to qualify, an employee must file a claim for COP in writing within 30 days of the date of injury.

C. Controversion. To dispute, challenge, or deny the validity of a claim for continuation of pay.

D. Dependent. For compensation (i.e., disability benefits) purposes: a wife or husband; an unmarried child under 18 years of age or, if over 18, incapable of self-support, or a student (until reaching 23 years of age if completing 4 years of school beyond the high school level); or a wholly dependent parent. For entitlement to death benefits: all of the above and a parent, brother, sister, grandparent, or grandchild who was wholly or partially dependent on the deceased.

E. FECA Assistant. Coast Guard employees in the field who serve as points of contact for claimants. FECA Assistants ensure that forms are distributed, filled out completely and accurately, and forwarded to FECA Program Liaisons in a timely manner.

F. FECA Program Liaison. Coast Guard employees in field installations who are responsible for administering the workers' compensation program. These individuals process claims and serve as liaisons between employees and the OWCP district offices.

G. Federal Employees' Compensation Act (FECA). Provides compensation benefits to civilian employees for disability due to personal injury or disease sustained while in the performance of duty. It also provides for the payment of benefits to dependents if a work-related injury or disease causes an employee's death.

H. Fitness for Duty (FFD) Report. A medical examination which may be required in order to justify continued compensation.

2. I. Impartial Medical Examination (IME). A medical examination by a third doctor in cases where there is a conflict of opinion between the treating physician's medical opinion and that of the second doctor (i.e., either a Fitness for Duty or an OWCP-ordered second opinion). This examination is directed by OWCP, and the results of the IME will be decisive.

J. Leave Buyback. The process by which an employee can buy back sick or annual leave from the agency that was used during a period of OWCP-compensable disability.

K. Light/Limited Duty. Duties assigned to injured employees who are temporarily unable to perform their regular functions.

L. Loss of Wage Earning Capacity (LWEC). A claimant with a permanent partial disability, and compensation has been adjusted accordingly.

M. Occupational Disease/Illness. A condition produced in the work environment over a period longer than 1 workday or shift. It may result from systemic infections; continued or repeated stress or strain; exposure to toxins, poisons, or fumes; or other continuing conditions of the work environment.

N. Office of Workers' Compensation Programs (OWCP). An entity within the Department of Labor which is responsible for administering the Federal Employees' Compensation Act.

O. Preexisting Condition. A disability of any type which existed prior to a job-related injury. If there is any evidence that a preexisting condition is present, it must be addressed directly by the treating physician. The job-related condition must be clearly delineated from the preexisting condition.

P. Recurrence of Disability. A disability (either a traumatic injury or an occupational disease) which reappears when the same injury causes additional time loss from the job. There is no single event, action, or apparent reason for the recurrence of the disability except the previous injury.

Q. Rehabilitation. A permanent job accommodation for a current or former employee who is permanently and partially disabled as a result of a job-related injury.

R. Schedule Award. Limited term payments in cases where an employee suffers serious disfigurement of the head, face, or

2.R. (cont'd) neck, or for anatomical loss of or loss of use of parts of the body listed in a special index published by OWCP.

S. Traumatic Injury. A wound or other condition which is: (a) caused by external forces including physical stress and strain; (b) identifiable as to time and place of occurrence and a member or function of the body affected; (c) caused by a specific event or incident or series of events or incidents within a single work shift. It is this last criterion which sets apart a traumatic injury from an occupational disease.

CHAPTER 3. RESPONSIBILITIES

A. Employees will:

1. Use required safety equipment and take necessary safety precautions while on the job;

2. Immediately report (but no later than 24 hours after an injury occurs) to the employee's supervisor and FECA Program Liaison any work-related injury;

3. Accurately complete OWCP forms, as required;

4. Submit medical documentation when requested;

5. Accept light duty assignments within the employee's commuting area in the event of a partially disabling injury; and

6. Cooperate with supervisors and managers to reduce avoidable costs associated with workers' compensation.

B. Supervisors and managers will:

1. Familiarize themselves with their responsibilities in the area of workers' compensation;

2. Upon receiving notice of traumatic injury, take the following actions:

   a. Ensure that medical treatment is authorized by preparing and issuing Form CA-16;

   b. Ensure that employees receive Form CA-1, and upon receipt of the completed form from the employee, return the Receipt of Notice of Injury to the employee;

   c. Complete the supervisor's section on Forms CA-1 or CA-2 and any other forms as required, in a timely manner, and in accordance with operating guidance contained in this Instruction;

   d. Forward all completed forms to the FECA Program Liaison for review and submission to OWCP; and

   e. Advise the employee of the right to elect continuation of pay, or use sick or annual leave;

3.B. 3. Take action to controvert a claim if there is substantial evidence that the claim may be fraudulent;

4. Inform the employee whether COP will be controverted, and if so, the basis for the controversion; and

5. Make every possible effort to reemploy individuals receiving compensation either in light duty or modified job assignments.

C. FECA Assistants will:

1. Assist employees and supervisors in correctly completing OWCP forms;

2. Review submitted OWCP forms for completeness and accuracy, and forward to FECA Program Liaison in a timely manner;

3. Maintain adequate supplies of all workers' compensation forms; and

4. Receive and take necessary action regarding OWCP materials such as forms, posters, pamphlets, etc.

D. FECA Program Liaisons will:

1. Administer the FECA Program for field installations;

2. Provide prompt assistance to employees and their immediate supervisors on all job-related injury or illness issues;

3. Assist and counsel employees and supervisors in correctly completing OWCP forms;

4. Review submitted OWCP forms for accuracy and completeness;

5. Act as liaison with the OWCP district office, promptly transmitting all forms and information to OWCP for adjudication;

6. Establish and maintain an OWCP file for each claim submitted and include in that file copies of all claim forms, medical reports, correspondence, and other materials related to each compensation claim in an orderly fashion;

3.D. 7. Establish a working relationship with OWCP district offices;

8. Coordinate with employees, supervisors, and physicians to collect data and locate light/limited duty as necessary;

9. Maintain adequate supplies of all workers' compensation forms;

10. Maintain and incorporate changes made to this Instruction; and

11. Receive and take necessary action regarding OWCP materials such as forms, posters, pamphlets, etc.

E. Servicing Civilian Personnel Offices will:

1. Identify FECA Program Liaisons; communicate to Commandant (G-PC-4) their name, organizational designation, mailing address, and phone number; and report immediately any subsequent changes;

2. In conjunction with FECA Program Liaisons, take necessary actions to reemploy on a permanent basis employees who are able to return to work;

3. Provide other assistance to FECA Program Liaisons as required;

4. Complete the necessary forms for continuance of an employee's life or health insurance coverage;

5. Monitor contracts with private sector investigatory organizations and report results to Commandant (G-PC) as required; and

6. Maintain medical files in accordance with Federal Personnel Manual (FPM) Chapter 293.

CHAPTER 4. FECA BENEFITS

A. Medical Benefits.

1. The FECA provides compensation for any medical services needed to provide treatment to counteract or minimize the effects of any condition, disease, or injury judged to be causally related to Federal employment. There is no limit on the monetary amount of medical expenses paid nor on the length of time for which they are paid (as long as the need for medical treatment can be substantiated and related to the injury or disease sustained on the job).

2. OWCP has a fee schedule that limits medical reimbursements to certain dollar amounts. The medical provider must accept this as payment in full. The employee may not be billed for any difference.

3. Compensation will be paid for first aid, medical treatment, hospitalization, and expenses for travel to obtain medical treatment, as well as for any drugs, appliances, or other supplies directed for use by a qualified physician. However, OWCP will not pay for any preventive treatment.

B. Disability Benefits.

1. Compensation. For traumatic injuries or occupational diseases, employees are entitled to compensation for wage loss following a 3-day waiting period as follows:

   a. Employee without dependents -- 66 2/3 percent of the employee's regular pay.

   b. Employee with dependents -- 75 percent of the employee's regular pay.

   NOTE: In cases where the disability extends more than 14 calendar days, compensation will be paid for the 3-day waiting period.

   c. An employee's regular pay is the pay rate in effect on the date of injury, date of recurrence, or date disability began, whichever is higher. Also included are night and Sunday differential, holiday pay, hazard pay, and environmental differential. Overtime pay is not included.

4.B. 1. d. For Coast Guard auxiliarists, compensation will be determined on the basis of GS-9, step 1, if the injury occurred on or after December 29, 1981. If the injury occurred before December 29, 1981, compensation will be based on a salary of $600 per month.

2. Types of Disability. For purposes of disability benefits, three categories of disability exist.

a. Temporary total disability. Medical evidence shows that an employee is totally disabled to perform any type of work for a certain period of time.

b. Permanent total disability. Injuries are so severe that they leave the employee permanently and totally disabled for any type of work.

c. Permanent partial disability. A job-related injury which prevents the employee from performing the job held at the time of injury; however, it may not prevent the employee from performing the duties of some other type of position. Compensation for these employees will be reduced to reflect the employee's improved wage-earning capacity.

3. Other Benefits Related to Disability.

a. Attendant's allowance. If an injury is so severe that the employee is unable to care for his/her physical needs (e.g., feeding, bathing, dressing, etc.), an attendant's allowance of up to $500 per month may be granted. This is a supplemental allowance, paid in addition to compensation for loss of wages, and can be given with all classes of disability.

b. Schedule awards. Compensation is provided for specified periods of time for the permanent loss, or loss of use, of certain parts and functions of the body. Partial loss or loss of use of these parts and functions is compensated on a proportional basis. Such compensation is calculated in the same manner as that which is paid for total disability (i.e., employee without dependents - 66 2/3 percent of regular pay; employee with dependents - 75 percent of regular pay). However, this compensation is paid only for a specified time period proportional to the severity of loss. Determining the severity of loss

4. B. 3. b. (cont'd) requires medical judgment by OWCP through the use of the American Medical Association's "Guides to the Evaluation of Permanent Impairment." Employees may receive compensation for wage loss and schedule award benefits for the same injury, but not at the same time. Consideration for a schedule award may be requested by submitting form CA-7.

c. Vocational rehabilitation. The FECA provides for the cost of OWCP-directed vocational rehabilitation necessary to counteract the disabling compensable effects of any permanent job-related illness or injury. The cost of rehabilitation is paid from the Compensation Fund and is usually administered through private and State vocational rehabilitation agencies under the direction of OWCP. Compensation will be terminated when the employee returns to work, unless the new job pays less than the old. In that case, compensation will be reduced to reflect the difference between the previous and current earnings. Should an employee refuse to cooperate or make a good faith effort to obtain reemployment, OWCP may reduce or terminate compensation depending on the circumstances of the refusal.

d. House and vehicle modifications. An employee whose injury severely restricts mobility and independence in the normal functions of living, either permanently or for a prolonged period, may be entitled to house or vehicle modifications. The employee may apply for such modifications by narrative letter. They must be recommended by the attending physician and must be consistent with the employee's preinjury standard of living.

C. Death Benefits.

1. Entitlement. The following individuals are entitled to compensation:

a. A widow or widower;

b. An unmarried child under the age of 18, or over the age of 18 who is incapable of self-support due to mental or physical disability;

c. A child between 18 and 23 years of age who has not completed 4 years of post high school education and is regularly pursuing a full-time course of study;

4. C. 1. d. A parent, brother, sister, grandparent, or grandchild who was wholly or partially dependent on the deceased.

2. Compensation Payments.

a. Widows and widowers of deceased employees are eligible for wage loss compensation equal to 50 percent of the deceased employee's regular pay.

b. If the widow or widower has an eligible child, he/she is eligible for compensation equal to 45 percent of the employee's regular pay, plus an additional 15 percent for each child, to a maximum which shall not exceed 75 percent of the deceased employee's regular pay.

c. If the deceased employee leaves no spouse, the aggregate family benefit will be determined as follows: the first child is entitled to 40 percent and each additional child is entitled to 15 percent of the employee's regular pay, up to a maximum of 75 percent, payable on an equal basis to all children.

d. An employee's regular pay is the pay rate in effect on the date of injury, date of recurrence, or date disability began, whichever is higher. Also included are night and Sunday differential, holiday pay, hazard pay, and environmental differential. Overtime pay is not included.

3. Funeral and Burial Expenses. Up to $800 will be paid for funeral and burial expenses. If the employee dies away from the area of residence, the cost of transporting the body to the place of burial will be paid in full. Itemized funeral bills should be submitted to OWCP for consideration of payment. In addition, a $200 allowance will be paid in consideration of the expense of terminating the deceased's status as a Federal employee.

CHAPTER 5. CONDITIONS OF COVERAGE FOR COMPENSATION CLAIMS

A. Conditions for Acceptable Claims. In reviewing claims and determining their acceptability, OWCP reviews each claim submitted to ensure that the following five conditions exist.

1. Time Limits for Filing Claims. The law provides that a claim for compensation must be filed within 3 years of the date of injury or death. If a claim for compensation is not filed within these time limits, compensation may still be allowed if written notice of injury was given in 30 days or the immediate superior had actual knowledge of the injury or death within 30 days after occurrence. Different provisions apply with respect to timeframes for filing claims for injuries occurring before September 7, 1974. The appropriate OWCP district office should be contacted in these rare cases.

2. Civil Employee. If the claim for compensation has been timely filed, a determination must be made as to whether the injured or deceased individual was an appropriated fund civilian employee or Coast Guard auxiliarist.

3. Fact of Injury. In determining whether the employee in fact sustained an injury or disease, two factors are involved.

   a. Occurrence of Event. A determination as to whether the employee actually experienced the accident, event, or employment factor which is alleged to have occurred is based on factual evidence. If the supervisor or servicing civilian personnel office believes that a claimant's testimony is contrary to the facts and circumstances of the injury, pertinent information to support those beliefs should be prepared by the FECA Program Liaison and submitted to OWCP.

   b. Medical Condition. Whether the accident resulted in an injury or disease is determined on the basis of the attending physician's statement that a medical condition is present which may be related to the incident.

4. Performance of Duty. If the above criteria have been accepted, a determination must then be made as to whether the employee was injured while in the performance of official duties.

5. A. 5. Causal Relationship. The last criterion examined in approving a claim for compensation is whether or not a causal relationship exists between the condition claimed and the injury or disease sustained. A determination almost always requires reasoned medical opinion from a physician who has examined or treated the employee for the condition claimed. Any injury or disease may be related to employment factors in any one of four ways:

a. Direct causation (the injury or factors of employment result in the condition claimed through a natural and unbroken sequence);

b. Aggravation (a preexisting condition is worsened by an injury arising in the course of employment);

c. Acceleration (an employment-related injury or disease hastens the development of an underlying condition); or

d. Precipitation (a latent condition which would not have manifested itself on this occasion but for the employment).

B. Statutory Exclusions. OWCP will deny compensation benefits if it has been asserted and proven (either by the Coast Guard or OWCP) that the cause of the injury or death is one of the following:

1. Willful misconduct;

2. Intoxication (e.g., alcohol or controlled substances without a medical prescription); or

3. Intention to bring about injury or death to oneself or another.

CHAPTER 6. PROCESSING CLAIMS

A. Special Claims. All claims for the following categories of employees are to be sent to the OWCP Special Claims Branch (District 25):

1. Employees injured outside of the United States;

2. Members of the Coast Guard Auxiliary and temporary members of the Coast Guard Reserve;

3. Individuals claiming exposure to AIDS; and

4. Individuals claiming exposure to Agent Orange.

B. Submission of Forms.

1. Reporting First Aid Injuries. OWCP has designated certain kinds of injuries as "first aid" injuries based on the extent of treatment required, and has also defined the circumstances under which they must be reported. Where these cases occur, the back of Form CA-1 is to be annotated with the statement "First Aid Only Case" in the upper right hand corner above item 17. There are three types of cases involving no loss of time from work.

   a. Where an employee obtains no medical treatment at all or obtains medical care without expense only on the date of injury. No medical treatment is obtained after the date of injury and no time loss is charged to either leave or continuation of pay. Form CA-1 for such cases are not reported to OWCP. The FECA Program Liaison will forward the CA-1 to the servicing civilian personnel office for inclusion in the Employee Medical Folder.

   b. Where medical expense is incurred but no time loss from work (represented by a charge to leave or continuation of pay) is charged. These cases must be reported to OWCP.

   c. Where an employee has one or more visits to a medical facility for examination or treatment during working hours beyond the date of injury as long as no leave or continuation of pay is charged to the employee and no medical expense is incurred. Also included in this group are cases which require two or more visits to a medical facility for examination or treatment during non-duty hours beyond the date of injury as

6. B. 1. c. (cont'd) long as no leave or COP is charged and no medical expense is incurred. These injuries are designated as first aid injuries and must be reported to OWCP using form CA-1.

2. Traumatic Injury (Form CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation). This is the first form that is filed in connection with a traumatic injury and should be completed by the employee (or someone acting on the employee's behalf) and submitted to the supervisor as soon as possible but not later than 30 days from the date of injury. The supervisor completes the supervisor's section and returns the "Receipt of Notice of Injury" at the bottom of form CA-1 to the employee. The CA-1 should then be forwarded to the FECA Program Liaison for review. The FECA Program Liaison will forward the CA-1 to the appropriate OWCP district office within 10 days after receipt from the employee if there is time loss, medical expenses, and/or anticipated disability. Otherwise, it should be retained in the employee's Employee Medical Folder by the servicing civilian personnel office.

   NOTE: The employee must file the CA-1 within 30 days from the date of injury in order to qualify for Continuation of Pay (see chapter 7, paragraph B).

3. Occupational Disease (Form CA-2, Notice of Occupational Disease and Claim for Compensation). This is used to report cases involving occupational diseases along with two copies of the checklist appropriate for the condition claimed (forms CA-35a through CA-35g). After submission by the employee, the supervisor will complete the supervisor's report on form CA-2 and return the "Receipt of Notice of Occupational Disease or Illness" at the bottom of form CA-2 to the employee. The form should then be forwarded to the FECA Program Liaison for review. The FECA Program Liaison will submit form CA-2 to OWCP within 10 days of receipt from the employee. It should not be held for receipt of supporting documentation.

4. Recurrences (Form CA-2a, Federal Employee's Notice of Recurrence of Disability and Claim for Continuation Pay/Compensation). This form is used when the same injury causes additional time loss from the job. A recurrence is distinguished from a new injury by the criterion that in a recurrence, no event other than the previous injury accounts for the disability. Upon receipt from the employee, the supervisor will complete

6.B. 4. (cont'd) the "Supervisor's Report" and forward form CA-2a to the FECA Program Liaison for review and submission to OWCP.

5. Medical Treatment (Form CA-16, Authorization for Examination and/or Treatment; Form OWCP-1500, Health Insurance Claim Form).

a. If an employee requires medical treatment only in traumatic injury cases, the supervisor must promptly (within 4 hours) complete and issue form CA-16 to a physician or hospital of the employee's choice. This form may not be used in occupational disease cases without prior approval from OWCP. If there is any doubt as to whether the employee has a job-related condition, the supervisor should so indicate on the CA-16. A copy of form CA-16 will be forwarded to the FECA Program Liaison for inclusion in the OWCP case file. In an emergency situation where there is not time to complete form CA-16, medical treatment may be authorized by phone and the form forwarded to the medical facility within 48 hours.

NOTE: Special care must be exercised in issuing this form since "authorization" guarantees payment of medical bills for up to 60 days or until OWCP withdraws authorization.

b. In conjunction with issuance of the CA-16, an employee should be issued form OWCP-1500. This form should be completed by the physician and is used to request payment for medical bills received from sources other than a hospital. All doctor bills not directly related to a hospital stay and sent by the hospital must be submitted on this form or the bill will not be paid and will be returned to the doctor. Hospitals need not use form OWCP-1500 but instead may submit itemized computerized bills.

6. Medical Reports (Form CA-16, Authorization for Examination and/or Treatment; Form CA-20, Attending Physician's Report; Form CA-20a, Attending Physician's Supplemental Report). In all cases sent to OWCP, a medical report is required from the attending physician and may be made on the above forms. CA-20 and CA-20a are attached to the compensation claim forms, CA-7 and CA-8, respectively.

6.B. 7. Duty Status Reports (Form CA-17, Duty Status Report). This form can be used at any time to request information from the attending physician regarding the employee's ability and restrictions regarding return to work. Under most circumstances, it should be sent every 2 weeks, but it may be sent more often if there is some doubt as to the extent of the employee's disability.

8. Claims for Compensation (Form CA-7, Claim for Compensation on Account of Traumatic Injury; Form CA-8, Claim for Continuing Compensation on Account of Disability).

a. Form CA-7 is initiated by the employee and used to claim compensation for wages lost for the following reasons:

(1) Due to a work-related traumatic injury (after the expiration of COP);

(2) Due to an occupational disease; or

(3) To initiate a claim for a schedule award. However, a claim for a schedule award should not be made on the same form as a claim for compensation for wage loss; rather, a separate CA-7 should be used.

NOTE: Forms CA-1 or CA-2 must be on file with OWCP before a CA-7 can be processed.

b. Form CA-8 is a claim for continuing compensation and must be submitted to OWCP 10 days before the expiration of the period claimed on form CA-7 (or a previously submitted CA-8).

NOTE: A CA-8 cannot be used without first having a CA-7 on file.

c. Form CA-7 or CA-8 should be initiated by the employee and submitted to the supervisor for completion of the section "Statement of Official Superior." Upon completion, the form will be submitted to the FECA Program Liaison for review and submission to OWCP.

9. Termination of Disability (Form CA-3, Report of Termination of Disability and/or Payment). This form should be initiated and completed by the supervisor when the employee returns to work, entitlement to COP ends, or

6. B. 9. (cont'd) the disability ceases, unless the CA-3 information was previously reported to OWCP on other forms (i.e., CA-1, CA-7, CA-8). It should then be forwarded to the FECA Program Liaison and submitted to OWCP.

10. Death of an Employee (Form CA-5, Claim for Compensation by Widow, Widower, and/or Children; Form CA-5b, Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren; Form CA-6, Official Superior's Report of Employee's Death).

a. An employee's work-related death should immediately be reported by the immediate supervisor to OWCP through the FECA Program Liaison using form CA-6. FECA Program Liaisons should contact the employee's survivors, provide them with either form CA-5 or CA-5b, as appropriate, and assist the survivors in preparing the claim as much as possible. When submitting these forms to OWCP, the following must also be included:

(1) a certified copy of the death certificate;

(2) a certified marriage certificate if a spouse is making claim;

(3) a copy of any divorce or annulment decree if the decedent or spouse was formerly married; and

(4) certified copies of birth certificates of any children for whom claim is made.

b. In addition to notifying OWCP, the immediate supervisor is required to notify the Occupational Safety and Health Administration (OSHA) within 48 hours of each occupational fatality or inpatient hospitalization of five or more people. Deaths occurring within 6 months of an occupational incident must also be reported within 48 hours. Notification can be made by telephone and must include the following:

(1) Names of individuals involved;

(2) Number of fatalities and/or injuries and their extent;

B. 10. b. (3) Establishment name, time, date, location, type of accident, and kind of operation conducted at the accident site; and

(4) Actions taken by the Coast Guard to investigate the accident and whether OSHA assistance is desired.

C. Claim Forms Review. Each FECA Program Liaison will be responsible for reviewing claim forms using this Instruction and the detailed instructions attached to the form before submitting them to OWCP. Incomplete forms will be returned by OWCP. Original forms must be submitted to OWCP with a copy retained in the OWCP claim file. The following claims review procedures will be followed by FECA Program Liaisons:

1. Examine the claim form (CA-1 or CA-2);

2. Investigate any discrepancies, omissions, or other problems that may be evident;

3. Review the initial medical report; and

4. Send all basic information bearing on the claim to OWCP to permit adjudication. If the FECA Program Liaison is investigating facts or getting an acceptable medical report and will need additional time, the claim and available documentation must forwarded with a note that other evidence is forthcoming.

5. Set up the OWCP claim file by employee name and date of injury. A copy of every document issued, received, and sent concerning the employee should be maintained in this file.

D. Occupational Safety and Health Administration (OSHA) Coding. OSHA uses injury and illness data from compensation claim forms submitted under the FECA and provided by OWCP. In order to assist OSHA in gathering needed data, it is required that type, source, and occupation data be coded on forms CA-1, CA-2, and CA-6 prior to submission of the form to OWCP.

1. Occupation Code.

a. FECA Program Liaisons will identify the employee's occupation by writing the appropriate code in the shaded box "a" on forms CA-1 or CA-2, or in block 22a on form CA-6.

6.D. 1. b. For most employees, the code begins with the two letters of the employee's pay plan (i.e., GS, GM, WG, etc.), followed by the four numbers of the occupation series. For example, the occupation code for a Secretary would be: GS0318.

c. For eligible individuals who do not have the usual job classification system titles, the following occupation codes must be used. Each code begins with the characters "??" instead of the usual pay plan letters.

Code	Title
??009900	College Work/Study Participant (non-Cooperative Education Student
??020400	Coast Guard Auxiliary Member
??024300	Neighborhood Youth Corps Enrollee
??024300	Job Corps Enrollee
??174000	Reader for the Blind
??350600	Student/Summer Aide (other than those in the GW or WW pay plans)

2. Type and Source of Injury Codes.

a. The type of injury code describes the action which was the initiating cause of the injury or illness. The source of injury code identifies the object or substance which was the initiating cause of the injury or illness. Together, they form a brief description of how the incident occurred. The following are examples of their use.

(1) An auxiliarist, while teaching a boating safety class, tripped on carpet and struck head on a desk.

Type: 210 - fell on same level
Source: 0110 - walking/working surface

(2) A nurse contracted hepatitis after being punctured by a contaminated needle.

Type: 410 - punctured by
Source: 0831 - needle

6. D. 2. a. (3) A shipfitter inhales asbestos fibers.

Type: 710 - inhaled
Source: 0621 - asbestos

(4) An employee driving a Government vehicle on official business is struck by another car.

Type: 800 - traveling in
Source: 0421 - Government-owned vehicle as a driver.

b. The type and source of injury codes should describe the initiating cause of the injury, rather than the outcome (i.e., example (1) would not be 120 - struck against; and 0140 - furniture).

c. The FECA Program Liaison will write a 3-digit type of injury code and a 4-digit source of injury code in the shaded boxes "b" and "c" on forms CA-1 and CA-2, and in blocks 22b and 22c on form CA-6. A listing of these codes are included as enclosure (18) to this Instruction.

3. Office of Workers' Compensation Programs (OWCP) Agency Code.

a. The Office of Workers' Compensation Programs (OWCP) agency code is a 4-digit code used by OWCP to identify the employing agency. The Coast Guard's agency code is 2550. FECA Program Liaisons must precode the agency identification code on forms CA-1, CA-2, CA-2a, and CA-6. This has been done on the forms included in this Instruction and shown as enclosures (2), (3), (4), and (8), respectively.

b. Blocks for the code are provided next to the employing agency's address in the "Supervisor's Report" portion of forms CA-1, CA-2, and CA-2a (block 17, CA-1; block 19, CA-2; block 24, CA-2a). On form CA-6, the code is placed in block 6.

4. Duty Station ZIP Code.

a. The ZIP Code of the employee's duty station should be included with the duty station street address in block 18 of the revised CA-1, and block 20 of the revised CA-2. On the CA-6, the ZIP Code should be written next to the Department or agency name in block 5.

6.D. 4. b. The ZIP Code indicated in these blocks must be the ZIP Code of the location of the injury, not the ZIP Code of the civilian personnel or safety office processing the compensation forms.

5. OSHA Site Code. If the OWCP agency code and duty station ZIP Code do not effectively distinguish agency locations, OSHA may require the development of OSHA site codes. At the present time, they are not required.

E. Supplies of Forms. Each FECA Program Liaison will be responsible for maintaining adequate supplies of all forms used in processing workers' compensation claims. These forms and instructions for completion have been included as enclosures to this Instruction. They may be duplicated on the same color paper as the original and used on an emergency basis. Enclosure (17) provides a table of all workers' compensation forms and their uses. The forms are as follows:

Enclosure No.	Form No.	Form Title
(2)	CA-1	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation
(3)	CA-2	Notice of Occupational Disease and Claim for Compensation
(4)	CA-2a	Notice of Employee's Recurrence of Disability and Claim for Pay/ Compensation
(5)	CA-3	Report of Termination of Disability and/or Payment
(6)	CA-5	Claim for Compensation by Widow, Widower and/or Children
(7)	CA-5b	Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren
(8)	CA-6	Official Superior's Report of Employee's Death
(9)	CA-7	Claim for Compensation on Account of Traumatic Injury or Occupational Disease
(10)	CA-8	Claim for Continuing Compensation on Account of Disability
(11)	CA-16	Authorization for Examination and/or Treatment
(12)	CA-17	Duty Status Report
(13)	CA-20	Attending Physician's Report
(14)	CA-20a	Attending Physician's Supplemental Report
(15)	OWCP-1500	Health Insurance Claim Form

CHAPTER 7. CONTINUATION OF PAY (COP)

A. Introduction. In order to prevent an employee from suffering a financial hardship, the FECA provides that an employee's regular pay may be continued for up to 45 calendar days of wage loss due to disability and/or medical treatment following a traumatic injury. (If unable to work as a result of an occupational disease, an employee is not eligible for COP but is entitled to compensation benefits.) COP is a continuation of salary and is not considered to be an OWCP compensation benefit. Therefore, it is subject to income tax, retirement, and other deductions. After entitlement to COP is exhausted, the employee may apply for compensation or use leave. In all cases, OWCP has the final authority to determine whether the Coast Guard's action in paying or terminating COP is correct.

B. Eligibility. In order to be eligible for COP, the following conditions must exist:

1. The disability must be the result of a traumatic injury (not an occupational disease);

2. The loss of time from work must be certified by a physician as being a result of the job-related injury;

3. The employee must file a claim for COP in writing within 30 days from the date of injury; and

4. The first day of COP must be taken within 90 days from the date of injury.

C. Mandatory Controversion. The employee's supervisor must oppose COP if one of nine circumstances specified in Federal regulation exist. However, OWCP will make the final determination as to eligibility for COP. If the controversion is based on one of the nine acceptable categories, then Coast Guard may not continue pay. The nine categories which require controversion and termination of COP are as follows:

1. The disability is a result of an occupational disease or illness;

2. The employee is not an appropriated fund civilian employee or Coast Guard auxiliarist;

7. C. 3. The employee is neither a citizen nor a resident of the United States or Canada;

4. The injury occurred off Coast Guard premises, and the employee was not involved in official "off premises duties";

5. The injury was caused by the employee's willful misconduct, intent to bring about injury or death of self or another person, or was proximately caused by the employee's intoxication;

6. The injury was not reported on a form approved by the Secretary of Labor within 30 days following the injury;

7. Work stoppage first occurred 90 days or more following the injury;

8. The employee initially reports the injury after employment has been terminated; or

9. The employee is enrolled in the Civil Air Patrol, Peace Corps, Job Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

D. Controversion for Other Reasons. A supervisor may controvert COP based upon a reason other than those specified above. To do so, the supervisor must complete the applicable portion of the CA-1 form and submit it to OWCP through the FECA Program Liaison with detailed information and justification in support of the controversion. The Coast Guard may not terminate continuation of the employee's pay until the controversion is sustained by OWCP.

E. Counting COP. The following guidelines must be used in counting COP.

1. COP does not begin until after the date of injury unless the injury occurs before the employee's normal workday. For example, if the employee is injured at 10:00 a.m. on Tuesday, full duty status (administrative leave) should be reflected on Tuesday (the date of injury) and COP will start on Wednesday. However, if the employee is injured on the work premises at 8:00 a.m. on Tuesday and the workday does not begin until 8:30 a.m., the time card will reflect Tuesday as the start of COP.

2. COP is counted in calendar days, not workdays. This includes holidays and weekends (or days off). There is a

7.E. 2. (cont'd) maximum entitlement of 45 calendar days; however, they need not be consecutive days.

3. Only days are counted. For example, if an employee uses 2 hours for a doctor's appointment and works 6 hours, it must be counted as 1 day of COP.

F. Recurrences. If an employee returns to work without using all 45 calendar days of COP and then suffers a recurrence, that employee may elect to use the remaining COP days providing that no more than 90 days have elapsed since the date of first return to work (including part-time or light duty).

G. Termination of COP. If the disability ends before the expiration of the 45-day period, COP will be terminated. Such action will be reported to OWCP using Form CA-3 (see chapter 6, paragraph B.9).

H. Time Cards. Time and attendance personnel are responsible for reporting continuation of pay, leave without pay, annual and sick leave, and other types of leave related to workers' compensation, in accordance with time and attendance reporting requirements.

CHAPTER 8. EFFECT ON EMPLOYEE BENEFITS

A. Leave Buyback. If an injured employee elects to use sick or annual leave during a period of disability, the employee may at a later date, with the approval of the servicing civilian personnel office, buy back the leave used.

1. Conditions. In order to buy back leave used for any period, three conditions must exist:

   a. The servicing civilian personnel office must be willing to change the leave record from leave with pay to leave without pay;

   b. The employee must have used sick or annual leave during the period of disability; and

   c. OWCP must have approved the employee's claim for compensation benefits.

2. Processing. Once a compensation claim is approved by OWCP, a request to buy back leave should be made by completing Form CA-7 and submitting it to OWCP. OWCP will, in turn, send a letter (on Form CA-1207) to the employee. The reverse side of the CA-1207 should be completed as instructed and returned to OWCP. Form CA-1208 will then be sent to the employee and the servicing civilian personnel office informing them that the request for reinstatement of leave is approved.

3. Voluntary Leave Transfer Program. If a leave recipient under the Voluntary Leave Transfer Program elects to buy back annual leave, the amount of transferred annual leave bought back by the leave recipient should be restored to the leave donors.

B. Health Insurance.

1. Continuation of Enrollment. Health benefits enrollment will automatically continue for an employee (and family members under a family enrollment) who becomes a compensationer providing all of the following requirements are met at the time the employee becomes a compensationer.

   a. The employee must have been enrolled in a plan under the health benefits program for 5 years of service immediately preceding the start of compensation, or

8. B. 1. a. (cont'd) during all service since the employee's first opportunity to enroll, or continuously for the full period or periods of servicing beginning with the enrollment which became effective no later than December 31, 1964.

b. The employee must be receiving compensation.

c. OWCP must determine that the employee is unable to return to duty.

2. Transferring Enrollments to OWCP. The following provisions are in effect with respect to transferring health benefits enrollments to OWCP.

a. Health benefits enrollments will be transferred to OWCP only upon its request. Until such time, employees receiving compensation should be treated for health benefits purposes as any other employee in nonpay status.

b. As with other employees in nonpay status, health benefits enrollment will continue for up to 365 days. At the end of the pay period which includes the 365th day of continuous nonpay status, the enrollment must be terminated.

c. When requested by OWCP, enrollments will be transferred by the servicing civilian personnel office to OWCP using SF-2810, Notice of Change in Health Benefits Enrollment.

d. A health benefits enrollment previously transferred to OWCP will be transferred back to the Coast Guard when the employee returns to full-time duty and pay status provided the employee is eligible for continued coverage. If the employee is not eligible for either temporary or permanent continued coverage, the enrollment must be terminated.

3. Withholdings and Contributions. Whether or not OWCP requests transfer of enrollment, it will make health benefits withholdings and contributions from the date compensation began or the date following that on which the Coast Guard's withholdings and contributions ceased. When the employee receives compensation for fewer than 29 days, they will be treated as current Coast Guard employees.

8. C. Life Insurance.

1. Basic Life Insurance. An employee's regular life insurance will be continued without cost for 1 year if the employee is in a nonpay status. If the employee qualifies for compensation, life insurance coverage remains in force as long as benefits begin on or before 31 December 1989 and the employee is in receipt of compensation. If coverage terminates because of separation or completion of a 12-month nonpay status period, the employee may apply for an individual policy or apply for continuance of the existing life insurance coverage.

2. Optional Life Insurance. An employee may retain optional life insurance while receiving compensation if eligible to continue regular insurance and enrolled for no less than 5 years of service immediately preceding the disability or the full period or periods of service during which optional life insurance was available, if less than 5 years.

3. Procedures for Continuation. When an employee's insurance terminates, the following procedures must be followed:

   a. The servicing civilian personnel office must complete an SF-2819 and furnish it to the employee.

   b. If the employee decides to continue life insurance coverage as a compensationer, the servicing civilian personnel office must complete the SF-2821 and show the compensation claim number on the form. The SF-2821 should then be forwarded to the Office of Personnel Management (OPM) with any designations of beneficiary, all previous elections necessary to document the employee's right to continue coverage as a compensationer, and a completed SF-2818.

   c. Upon receipt of the completed SF-2821, OPM will verify with OWCP the employee's compensation status and inability to return to duty and will then inform the employee whether he or she remains insured.

D. Retirement. An employee who has a work-related disability or injury has the right to file for both an annuity under the retirement system and also compensation for work injuries. However, generally the employee may not receive an annuity and compensation for the same period of time. In counseling

8. D. (cont'd) employees about disability retirement versus compensation, the following points should be made:

1. The employee has the right to file for disability retirement.

2. The employee has the right to file for regular (optional) retirement benefits if he/she has the required length of service and age.

3. The employee has the right to file for retirement and at the same time file for compensation. If the retirement case is approved by the OPM, all rights are held in perpetuity until such time as the employee elects to claim them. The employee cannot receive both compensation and annuity payments at the same time.

4. If compensation is terminated or reduced at any time in the future, the employee would always be able to elect retirement (provided the original claim to the OPM has been approved).

5. It is not advisable to withdraw contributions made into the retirement fund. If the employee later dies for reasons unrelated to the job injury, and contributions have been withdrawn from the retirement fund, the employee's survivors would not be eligible for a survivor annuity based on the employee's Federal service.

CHAPTER 9. OBTAINING MEDICAL INFORMATION

A. Selecting a Physician. An employee is entitled to initial selection of a physician for treatment of a job-related injury. Any change in treating physician after the initial choice is made must be authorized by OWCP. If such authorization is not sought by the employee, OWCP will not be liable for the expenses of treatment. The Coast Guard has no authority to direct the transfer of medical care from one physician to another.

NOTE: Certain providers may be excluded from participation in the workers' compensation program. The names of these excluded medical providers along with those who have been reinstated are periodically published by OWCP and will be distributed by Commandant (G-PC-4). The services of excluded providers may not be reimbursed by OWCP during the period of exclusion.

B. Medical Examinations Desired by the Coast Guard. An individual who has applied for or is receiving continuation of pay or compensation as a result of an on-the-job injury or disease may be required to report for an examination to determine medical limitations that may affect placement decisions.

C. Evaluation of Claimant's Medical File. The OWCP District Medical Director or District Medical Advisor will review medical evidence submitted to OWCP by the claimant's treating physician.

D. Medical Examinations Ordered by OWCP. When medical opinions between the District Medical Director/Advisor and the claimant's treating physician differ, the conflict can be resolved only after examination by a qualified medical specialist chosen by OWCP. Such an exam is called an Impartial Medical Examination. The results of this examination are final. When any examination is ordered by OWCP, the costs associated with it (i.e., the medical examination itself, reasonable travel expenses, and wage loss) will be paid by OWCP.

CHAPTER 10. STAFFING AND PLACEMENT

A. Light Duty. One of the most effective means of reducing Coast Guard's compensation costs is to emphasize the use of light or limited duty. Such a program accommodates injured employees who are temporarily unable to perform their regular functions. Ideally, light duty assignments should be given by an employee's immediate supervisor and should be located within the employee's regular organizational unit. Sometimes the immediate supervisor has no way to usefully employ an injured employee. If such a determination is made, the search for a special temporary assignment should be coordinated by the FECA Program Liaison and broadened to include other organizational units. However, assignment with any Coast Guard organization in the commuting area should be considered.

1. OWCP Form CA-17 can be used at any time in traumatic injury cases to request information from the attending physician with regard to the employee's ability to return to work and with what restrictions. Normally this form is sent every 2 weeks but may be sent more frequently if some doubt exists as to the extent of the employee's disability.

2. It is critical that the supervisor does not assign any duties to the claimant that are not clearly within the work limitations imposed by the treating physician. If any doubt exists as to the employee's ability to perform certain duties, a job description should be sent to the attending physician for evaluation.

3. When the physician's report indicates that the employee is no longer totally disabled, the employee is required to accept any reasonable offer of suitable light duty. If the employee refuses to accept the work offered, COP should be terminated as of the date of the employee's refusal or after 5 workdays from the date of the offer, whichever is earlier.

4. If at any time, the employee refuses to provide sufficient medical information for the servicing civilian personnel office to evaluate the propriety of a job offer, OWCP will be notified.

10. B. Reemployment.

1. Guidelines. If the residuals of an injury will prohibit the employee from returning to the position held at the time of injury, and the employee has been in receipt of compensation for more than 1 year, a complete report on work limitations will be requested from the treating physician by the FECA Program Liaison using Form CA-17. Upon receipt of this report, reemployment will be considered in the following order of preference:

   a. Return the employee to the position held at the time of injury with modifications to accommodate the limitations;

   b. Place the employee in another position at the same salary as the position held at the time of injury; or

   c. Place the employee in another position at a lower salary than the position held at the time of injury.

2. Making a Job Offer. The servicing civilian personnel office may contact the employee by telephone regarding the availability of a job, but the offer must be confirmed in writing as soon as possible. In addition, a copy of the job offer letter must be sent to OWCP at the same time. The job offer should include the following:

   a. A description of duties to be performed;

   b. The specific physical requirements of the position and any special demands of the workload or unusual working conditions;

   c. The organizational and geographical location of the job;

   d. The date on which the job will be available; and

   e. The date by which a response to the job offer is required.

3. Employee's Response. When the employee responds to the job offer, a copy of the response must be forwarded to OWCP. In addition, the servicing civilian personnel office should notify OWCP of the date of return to duty in order to avoid overpayments of compensation. Benefits will be terminated or adjusted as of the date of return to duty.

10. C. Questionable Claims. Despite the best efforts to inform employees, it is possible that some will deliberately submit false injury compensation claims. When such offenses occur, supervisors and managers must dispute the validity of an employee's claim as a whole by carrying out the following procedures.

1. Reasons to Question Claims. Although not an all-inclusive list, some factors which may suggest the possibility of fraud are:

   a. Information exists that the claimant is acting in a manner inconsistent with claimed injury;

   b. Witnesses dispute the claimed injury;

   c. A single individual has a history of repeated similar claims;

   d. Several individuals in the same work area filed identical claims, especially if the claims are hard-to-diagnose injuries or illnesses (e.g., sprained back, hearing loss);

   e. Information exists that the claim was filed in conjunction with some threat to job security (e.g., disciplinary action, RIF, conversion to contract work, etc.);

   f. An employee waits a long period of time to report an injury and reports to work in the interim without appearing injured and is able to carry out normal job functions; or

   g. An employee is using leave, COP, or drawing compensation, and someone reports that the employee is working at another job.

2. Employee's Ability to Return to Work. Using OWCP Form CA-17, information must be requested from the attending physician with regard to the employee's ability to return to work and with what restrictions. Normally this form is sent every 2 weeks but may be sent more frequently if some doubt exists as to the extent of the employee's disability.

3. Light Duty Assignments. Upon receipt of the CA-17 from the attending physician, the FECA Program Liaison or

10. C. 3. (cont'd) servicing civilian personnel office will attempt to place the employee in a light duty assignment or reemploy on a permanent basis.

NOTE: When the treating physician fails to provide the requested medical information, a Fitness for Duty report may then be ordered from any qualified medical specialist (see Chapter 6, paragraph D.2).

4. Internal Investigations. After consideration of light duty assignments, the servicing civilian personnel office may refer the case to the Coast Guard investigation staff for further investigation of any fraud.

5. External Investigations. If internal Coast Guard investigation cannot be obtained, the servicing civilian personnel office may consider a contract with a private sector investigatory organization under the following conditions:

a. The contract must be monitored closely;

b. The contract must be in effect for the most limited period of time necessary to complete the investigation;

c. At the time the contract is established, a report must be submitted to Commandant (G-PC) which identifies the projected cost and length of the contract as compared to the savings expected to accrue with a successful investigation;

d. Upon termination of the contract, a final report must be submitted to Commandant (G-PC) which identifies the following:

(1) the actual cost of the contract;

(2) the results of the investigation;

(3) the compensation costs recovered, if any; and

(4) other pertinent information which justifies the cost of the contract.

6. Results of Investigations. If information is identified in the course of **any** investigation which leads the agency to question the validity of a claim, it should report the

10.C. 6. (cont'd) results of the investigation to the appropriate OWCP district office. All such allegations must be supported by **specific factual evidence** such as witness statements, pictures, accident investigations, etc. OWCP will consider all information submitted and correspond further with the parties involved if necessary. The authority to determine **any** aspect of a claim rests with OWCP. The agency is entitled to an explanation of the basis for OWCP's action but must accept the determination rendered.

CHAPTER 11. MANAGEMENT AND EVALUATION OF THE WORKERS' COMPENSATION PROGRAM

A. Compensation Costs. Workers' compensation costs for the Coast Guard have been dramatically increasing in recent years. These increases can be attributed to many factors including increased medical costs, legislation, Department of Labor administration of the program, attitudes toward the program, occupational safety and health environment, inflation, state of supervisor and employee knowledge and awareness of the program, and fraud and abuse. Some of these factors are not within the Coast Guard's ability to control but many can be controlled through the following administrative activity:

1. Light/limited duty must be provided in every instance where an injured employee is able to work;

2. Reemployment of rehabilitated employees from long-term compensation rolls must become a priority;

3. Employees must cooperate to reduce avoidable costs, take necessary safety precautions, and be aware that false compensation claims will not be tolerated; and

4. Supervisors and managers must be aware of the problem of increasing compensation costs, knowledgeable of the claims process and their roles in that process, and fully supportive of initiatives to reduce injury compensation costs.

B. Chargeback Listing. Compensation costs are paid directly to injured/disabled workers or their beneficiaries by OWCP. However, the law requires that each agency reimburse OWCP annually for all costs including medical costs, costs of vocational rehabilitation, compensation, death benefits, etc. The chargeback listing is the mechanism by which these costs are assigned to employing agencies. For chargeback purposes, this period runs from 1 July through 30 June of the following year.

1. Identification. The Department of Labor identifies each Coast Guard claim for compensation based on a code entered into the OWCP data processing system when the case is created. Each FECA Program Liaison will receive a postcard (Form CA-801) from OWCP each time a case is created. These postcards should be reviewed and errors reported to OWCP as soon as possible in order to avoid errors on the quarterly and yearly chargeback reports.

11.B. 2. Quarterly Chargeback Report. Each quarter, the Coast Guard is provided with a report which provides a breakdown of cases and costs for which charges will appear on the yearly chargeback bill. This report is used to identify and correct errors before the Coast Guard is billed for them. Such errors are immediately reported to OWCP by Commandant (G-PC).

3. Yearly Chargeback Bill. Each year, the Coast Guard is provided with a statement of payments made from the compensation fund based on injuries suffered by its employees. This amount is included in the budget request to Congress, and the resulting sums appropriated or obtained from operating revenues are deposited in the fund for the following year. Compensation billing is always "2 years in arears" (e.g., the bill for 1989 is for charges incurred in 1987).

FORM	TITLE	STOCK NUMBER AND UNIT PRICE
CA-1	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/ Compensation (3/86*)	029-016-00092-5 $ 19.00 per 100
CA-2	Notice of Occupational Disease and Claim for Compensation (3/86*)	029-016-00090-9 $ 20.00 per 100
CA-2a	Notice of Recurrence of Disability and Claim for Pay/Compensation (12/87*)	029-016-00101-8 $ 24.00 per 100
CA-3	Report of Termination of Disability and/or Payment (12/74*)	029-016-00024-1 $ 7.00 per 100
CA-5	Claim for Compensation by Widow, Widower, and/or Children (12/86*)	029-016-00097-6 $ 19.00 per 100
CA-5b	Claim for Compensation by Parents, Brothers, Sisters, Grandparents, Grandchildren (9/86*)	029-016-00096-8 $ 19.00 per 100
CA-6	Official Superior's Report of Employee's Death (11/86*)	029-016-00098-4 $ 11.00 per 100
CA-7/20	Claim for Compensation on Account of Traumatic Injury or Occupational Disease with CA-20, Attending Physician's Report (8/87*)	029-016-00095-0 $ 27.00 per 100
CA-8/20a	Claim for Continuing Compensation on Account of Disability with CA-20a, Attend. Phys. Supplemental Rep. (8/87*)	029-016-00094-1 $ 20.00 per 100
CA-16	Authorization for Examination and/or Treatment (8/87*)	029-016-00108-5 $ 22.00 per 100
CA-17	Duty Status Report (8/87*)	029-016-00099-2 $ 11.00 per 100
Checklists:	Evidence Required in Support of Claim for Occupational Disease:	
CA-35a	Occupational Disease (other)(8/85)	029-016-00081-0 $ 6.00 per 100
CA-35b	Hearing Loss (8/85)	029-016-00082-8 $ 6.00 per 100
CA-35c	Asbestos-Related Illness (10/87)	029-016-00103-4 $ 22.00 per 100
CA-35d	Work-Related Coronary/ Vascular Condition (8/85)	029-016-00084-4 $ 6.00 per 100
CA-35e	Work-Related Skin Disease (8/85)	029-016-00085-2 $ 6.00 per 100
CA-35f	Work-Related Pulmonary Illness (not asbestosis) (8/85)	029-016-00086-1 $ 6.00 per 100
CA-35g	Work-Related Psychiatric Illness (8/85)	029-016-00087-9 $ 6.00 per 100
CA-35h	Work-Related Carpal Tunnel Syndrome (10/87*)	029-016-00102-6 $ 11.00 per 100
CWCP-1500	Health Insurance Claim Form (medical billing form for FECA claimants) (3/88*)	029-016-00078-0 $ 6.50 per 100

* latest revision date as of December 6, 1988

Instructions for Completing Form CA-1

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

Employee (Or person acting on the employee's behalf)

13) Cause of Injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g.: if you fell, how far did you fall and in what position did you land?)

14) Nature of Injury

Give a complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg; cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and file CA-1 within thirty days of the injury, you are entitled to receive continuation of pay (COP) from your employing agency. COP is paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. You may elect sick or annual leave if you wish, but compensation from OWCP may not be claimed during the 45 days of COP entitlement. (You may not claim compensation to repurchase leave used during this period.) Also, if you later change your election, the agency is not obliged to convert past periods of leave to COP.

Your agency may controvert (dispute) your entitlement to COP, but must continue pay unless the controversion is based on one of the nine reasons listed in the instructions for item 35.

If you receive COP, but OWCP later determines that you are not entitled to COP, you may either change COP to sick or annual leave or pay the employing agency back for the COP received.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 38, the supervisor is responsible for obtaining the witness statement in item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within two working days after it is received.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.

17) Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

29) Was injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer whose defective product causes an employee's injury, could all be considered third parties to the injury.

31) Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

32) First date medical care received

The date of the first visit to the physician listed in item 31.

35) Does the employing agency controvert continuation of pay?

COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

a) The disability results from an occupational disease or illness;

b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;

c) The employee is neither a citizen nor a resident of the United States or Canada;

d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;

e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;

f) The injury was not reported on Form CA-1 within 30 days following the injury;

g) Work stoppage first occurred six months or more following the injury;

h) The employee initially reported the injury after his or her employment was terminated; or

i) The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Recordkeeping and Reporting Guidelines.

OWCP Agency Code

This is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Disability Benefits for Employees under the Federal Employees' Compensation Act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related, traumatic injuries:

(1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury; however, to avoid possible interruption of pay, the form should be filed within 2 working days. If the form is not filed within 30 days, compensation may be substituted for continuation of pay.)

(2) Payment of compensation for wage loss after the 45 days, if disability extends beyond such period.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where necessary.

(5) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians, of the employee's choice. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered in making selection of physicians or medical facilities.

At the time an employee stops work following a traumatic, job-related injury, he or she may request continuation of pay or use sick or annual leave credited to his or her record. Where the employing agency continues the employee's pay, the pay must not be interrupted until:

(1) The employing agency receives medical information from the attending physician to the effect that disability has terminated;

(2) The OWCP advises that pay should be terminated; or

(3) The expiration of 45 calendar days following initial work stoppage.

If disability exceeds, or it is anticipated that it will exceed, 45 days, and the employee wishes to claim compensation, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period. Form CA-3 shall be submitted to OWCP when the employee returns to work, disability ceases, or the 45 day period expires.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

Privacy Act

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that:

(1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the office receives and maintains personal information on claimants and their immediate families.

(2) The information will be used to determine eligibility for and the amount of benefits payable under the Act.

(3) The information may be used by other agencies or persons in matters relating directly or indirectly to the matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or complied with the provisions of 20 CFR 10.

(4) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury sustained by
(Name of injured employee)

Which occurred on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior | Title | Date (Mo., Day, Yr.)

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle) | 2. Social Security Number

3. Date of birth Mo. Day Yr. | 4. Sex ☐ Male ☐ Female | 5. Home telephone ( ) | 6. Grade as of date of injury Level Step

7. Employee's home mailing address (Include city, state, and zip code) | 8. Dependents ☐ Wife, Husband ☐ Children under 18 years ☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

10. Date injury occurred Mo. Day Yr. | Time : ☐ a.m. ☐ p.m. | 11. Date of this notice Mo. Day Yr. | 12. Employee's occupation

13. Cause of injury (Describe what happened and why)

a. Occupation code

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg) | b. Type code | c. Source code

OWCP Use - NOI Code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

Signature of employee or person acting on his/her behalf _____

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate provisions, be punished by a fine or imprisonment, or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

End of Employee Report

Witness

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness | Signature of witness | Date signed

Address | City | State | Zip Code

CA
(Rev. 3/8

Enclosure (2) to COMDTINST M12810.2

Official Supervisor's Report: Please complete information requested below

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and zip code) | OWCP Agency Code 2550

OSHA Site Code

Zip Code

18. Employee's duty station (Street address and zip code) Zip Code

19. Regular work hours From: : ☐ a.m. ☐ p.m. To: : ☐ a.m. ☐ p.m.

20. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

21. Date of injury Mo. Day Yr.

22. Date notice received Mo. Day Yr.

23. Date stopped work Mo. Day Yr. Time : ☐ a.m. ☐ p.m.

24. Date pay stopped Mo. Day Yr.

25. Date 45 day period began Mo. Day Yr.

26. Date returned to work Mo. Day Yr. Time : ☐ a.m. ☐ p.m.

27. Was employee injured in performance of duty? ☐ Yes ☐ No (If "No," explain)

28. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☐ No

29. Was injury caused by third party? ☐ Yes ☐ No (If "No," go to item 31.)

30. Name and address of third party (include city, state, and zip code)

31. Name and address of physician first providing medical care (include city, state, zip code)

32. First date medical care received Mo. Yr.

33. Do medical reports show employee is disabled for work? ☐ Yes ☐ No

34. Does your knowledge of the facts about this injury agree with statements of the employee and/or witness? ☐ Yes ☐ No (If "No," explain)

35. Does the employing agency controvert continuation of pay? ☐ Yes (If "Yes," explain) ☐ No
(See instructions for explanation of "controvert")

36. Pay rate when employee stopped work
$ Per

Signature of Supervisor and Filing Instructions

37. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)

Signature of supervisor Date

Supervisor's Title Office phone

38. Filing instructions
☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
☐ No lost time, medical expense incurred or expected: forward this form to OWCP
☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP

CA-
(Rev. 3/8

Instructions for Completing Form CA-2

Enclosure (3) to COMDTINST M12810.2

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. In addition to the information requested on the form, both the employee and the supervisor are required to submit additional evidence as described below. If this evidence is not submitted along with the form, the responsible party should explain the reason for the delay and state when the additional evidence will be submitted.

Employee (or person acting on the employee's behalf)

Complete items 1 through 18 and submit the form to the employee's supervisor along with the statement and medical reports described below. Be sure to obtain the Receipt of Notice of Disease or illness completed by the the supervisor at the time the form is submitted.

1) Employee's statement

In a separate narrative statement attached to the form, the employee must submit the following information:

a) A detailed history of the disease or illness from the date it started.

b) Complete details of the conditions of employment which are believed to be responsible for the disease or illness.

c) A description of specific exposures to substances or stressful conditions causing the disease or illness, including locations where exposure or stress occurred, as well as the number of hours per day and days per week of such exposure or stress.

d) Identification of the part of the body affected. (If disability is due to a heart condition, give complete details of all activities for one week prior to the attack with particular attention to the final 24 hours of such period.)

e) A statement as to whether the employee ever suffered a similar condition. If so, provide full details of onset, history, and medical care received, along with names and addresses of physicians rendering treatment.

2) Medical report

a) Dates of examination or treatment.

b) History given to the physician by the employee.

c) Detailed description of the physician's findings.

d) Results of x-rays, laboratory tests, etc.

e) Diagnosis.

f) Clinical course of treatment.

g) Physician's opinion as to whether the disease or illness was caused or aggravated by the employment, along with an explanation of the basis for this opinion. (Medical reports that do not explain the basis for the physician's opinion are given very little weight in adjudicating the claim.)

3) Wage loss

If you have lost wages or used leave for this illness, Form CA-7 should also be submitted.

Supervisor (Or appropriate official in the employing agency)

At the time the form is received, complete the Receipt of Notice of Disease or Illness and give it to the employee. In addition to completing items 19 through 34, the supervisor is responsible for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form must be sent to OWCP within ten working days after it is received. In a separate, narrative statement attached to the form, the supervisor must:

a) Describe in detail the work performed by the employee. Identify fumes, chemicals, or other irritants or situations that the employee was exposed to which allegedly caused the condition. State the nature, extent, and duration of the exposure,including hours per days and days per week. requested above.

b) Attach copies of all medical reports (including x-ray reports and laboratory data) on file for the employee.

c) Attach a record of the employee's absence from work caused by any similar disease or illness. Have the employee state the reason for each absence.

d) Attach statements from each co-worker who has first-hand knowledge about the employee's condition and its cause. (The co-workers should state how such knowledge was obtained.)

e) Review and comment on the accuracy of the employee's statement requested above.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

Item Explanations Some of the items on the form which may require further clarification are explained below.

14. Nature of the disease or illness

Give a complete description of the disease or illness. Specify the left or right side if applicable (e.g., rash on left leg; carpal tunnel syndrome, right wrist).

19. Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (If applicable, the address of the personnel or compensation office).

20. Employee's duty station, street address and zip code

The street address and zip code of the establishment where the employee actually works.

23. Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

24. First date medical care received

The date of the first visit to the physician listed in item 23.

32. Was the injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the disease. For instance, manufacturer of a chemical to which an employee was exposed might be considered a third party if improper instructions were given by the manufacturer for use of the chemical.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Record Keeping and Reporting Guidelines.

OWCP Agency Code

This is a four digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Liability Benefits for Employees under Federal Employees' Compensation Act

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following general benefits for employment-related occupational disease or illness:

(1) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians of the employee's choice.

(2) Payment of compensation for total or partial wage loss.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where necessary.

The first three days in a non-pay status are waiting days, and no compensation is paid for these days unless the period of disability exceeds 14 calendar days, or the employee has suffered a permanent disability. Compensation for total disability is generally paid at the rate of 2/3 of an employee's salary if there are no dependents, or 3/4 of salary if there are one or more dependents.

If an employee is in doubt about compensation benefits, the OWCP District Office servicing the employing agency should be contacted. (Obtain the address from your employing agency.)

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

Privacy Act

In accordance with the Privacy Act of 1974 (Public Law No. 93-570, 5 U.S.C. 552a), you are hereby notified that:

(1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the office receives and maintains personal information on claimants and their immediate families.

(2) The information will be used to determine eligibility for and the amount of benefits payable under the Act.

(3) The information may be used by other agencies or persons in matters relating directly or indirectly to the matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or complied with the provisions of 20 CFR 10.

(4) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).

Receipt of Notice of Occupational Disease or Illness

This acknowledges receipt of notice of disease or illness sustained by:
(Name of injured employee)

I was first notified about this condition on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior | Title | Date (Mo., Day, Yr.)

This receipt should be retained by the employee as a record that notice was filed.

Notice of Occupational Disease and Claim for Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle)

2. Social Security Number

3. Date of birth Mo. Day Yr.

4. Sex

5. Home telephone ( )

6. Grade as of date of last exposure Level Step

7. Employee's home mailing address (include city, state, and zip code)

Zip Code

8. Dependents
- ☐ Wife, Husband
- ☐ Children under 18 years
- ☐ Other

Claim Information

9. Employee's occupation

a. Occupation code

10. Location (address) where you worked when disease or illness occurred (include city, state, and zip code)

11. Date you first became aware of disease or illness Mo. Day Yr.

12. Date you first realized the disease or illness was caused or aggravated by your employment Mo. Day Yr.

13. Explain the relationship to your employment, and why you came to this realization

14. Nature of disease or illness

OWCP Use - NOI Code

b. Type code

c. Source code

15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain the reason for the delay.

16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.

17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.

Employee Signature

18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with the United States Government, and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

Signature of employee or person acting on his/her behalf _____ Date _____

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate provisions, be punished by a fine or imprisonment, or both.

For sale by the Superintendent of Documents, U.S. Government Printing Office Washington, DC 20402

CA-2
(3/86)

Official Supervisor's Report of Occupational Disease: Please complete information requested below

Supervisor's Report

19. Agency name, and address of reporting office (Include city, state, and zip code) | OWCP Agency Code 2550

OSHA Site Code

Zip Code

20. Employee's duty station (Street address and zip code)

Zip Code

21. Regular work hours From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

22. Regular work schedule ☐Sun. ☐Mon. ☐Tues. ☐Wed. ☐Thurs. ☐Fri. ☐Sat.

23. Name and address of physician first providing medical care (Include city, state, zip code)

24. First date medical care received Mo. Day Yr.

25. Do medical reports show employee is disabled for work? ☐Yes ☐No

26. Date employee first reported condition to supervisor Mo. Day Yr.

27. Date and hour employee stopped work Mo. Day Yr. Time : ☐a.m. ☐p.m.

28. Date and hour employee's pay stopped Mo. Day Yr. Time : ☐a.m. ☐p.m.

29. Date employee was last exposed to conditions alleged to have caused disease or illness Mo. Day Yr.

30. Date returned to work Mo. Day Yr. Time : ☐a.m. ☐p.m.

31. If employee has returned to work and work assignment has changed, describe new duties

32. Was injury caused by third party? ☐Yes ☐No If "No," go to item 34.

33. Name and address of third party (Include city, state, and zip code)

Signature of Supervisor

34. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of Supervisor (Type or print)

Signature of Supervisor Date

Supervisor's Title Office phone

INSTRUCTIONS FOR COMPLETING FORM CA-2a RECURRENCE OF DISABILITY

DEFINITION OF RECURRENCE

Recurrence - when an employee who sustained an occupational injury or disease suffers disability for work due to the original injury, and such disability occurs after the employee returned to work following the injury, and the disability is the result of (1) a spontaneous return of the symptoms of the previous injury or disease without intervening cause, or (2) the need for medical treatment, other than a usual office call, for residuals of the previous condition. In these instances Form CA-2a is required. If a new incident or injury occurs which precipitates the disability, even if the injury is to the same part of the body previously injured, or is new exposure to the same cause(s) of a previously suffered occupational disease, this constitutes a new injury and Form CA-1 or CA-2 should be filed accordingly.

INSTRUCTIONS FOR EMPLOYEE

- Review the definition of recurrence provided above. If you have suffered a recurrence, you should complete Part A completely. Attach a separate sheet of paper where necessary to provide full details.
- If you are employed by the Federal Government at the time of recurrence, Form CA-2a should be submitted promptly to your employing agency. If you are no longer employed with the Federal Government, you should complete Parts A and C and submit all materials directly to OWCP.
- If the original injury was not previously reported to OWCP, a report specifically covering the original injury should be made on Form CA-1 (traumatic injury) or CA-2 (occupational disease) and attached when Form CA-2a is submitted. Medical reports concerning the original injury should also be attached, if not previously submitted.
- If this is a recurrence of an occupational disease, or if the 45 days Continuation of Pay (COP) have been exhausted, you may claim wage loss on Form CA-7 if this form was not submitted following original injury. If Form CA-7 was previously submitted, compensation may be claimed on Form CA-8. The OWCP will be responsible for payment of compensation if the claim is approved.
- You should arrange for the submission of a detailed medical report from your attending physician. The report should include: dates of examination and treatment; history given by the employee; findings; results of x-ray and lab tests; diagnosis; course of treatment, and the physician's opinion, with medical reasons, regarding causal relationship between your condition and the original injury. The physician should also describe your ability to perform your regular duties. If you are disabled for your regular work, (s)he should identify the dates of disability and provide work tolerance limitations.
- If you were treated by other physicians after returning to work following the original injury, similar medical reports should be obtained from each.

INSTRUCTIONS FOR THE EMPLOYING AGENCY

- Upon receipt of a claim for recurrence, the employing agency should promptly complete Part B and submit it to OWCP.
- Where pay is continued, the employing agency should obtain medical evidence on Form CA-17, "Duty Status Report", as often as circumstances indicate.
- If the recurrent disability has not ended at the time Form CA-2a is submitted, Form CA-3, Report of Termination of Disability and/or Payment, should be forwarded when the employee returns to work.
- If the recurrence happens less than six months following employee's return to work following the injury, the supervisor shall authorize required medical care by use of Form CA-16. If the recurrence happens more than six months after the employee's return to work, authorization for further medical care must be obtained from the OWCP.
- If the recurrent disability continues after the expiration of the 45 days Continuation of Pay (COP) or if this is a recurrence of an occupational disease, you should instruct the employee to file Form CA-7. If Form CA-7 was previously submitted, compensation should be claimed on Form CA-8.

Federal Employee's Notice of Recurrence of Disability and Claim for Continuation Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete Part A below.
Employing Agency (Supervisor or Compensation Specialist): Complete Part B.

OMB No. 1215-0167
Expires: 07-31-90

Employee Data Part A - Employee

1. Name of employee (Last, First, Middle)	2. Social Security Number	3. OWCP file number for original injury (if known)

4. Date of birth Mo. Day Yr.	5. Sex	6. Home telephone
	☐ Male ☐ Female	( )

7. Employee's home mailing address (include city, state, and zip code)	8. Dependents
	☐ Wife, Husband ☐ Children under 18 years ☐ Other

9. Name and Address of Employing Establishment at time of original injury (number, street, city, state, zip code)	10. Name and Address of Employing Establishment at time of recurrence, if other than 9. If you are no longer employed with the Federal Government, complete Part C in addition to Part A.

11. Date and Hour of original injury (mo., day, year)	12. Date and Hour of recurrence (mo., day, year)	13. Date and Hour stopped work following recurrence (mo., day, year)	14. Date and Hour pay stopped following recurrence (mo., day, year)	15. Date and Hour returned to work (mo., day, year)
☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.

16. Dates of medical treatment following recurrence (mo., day, year)	17. Name and Address of physician treating employee following recurrence

18. After returning to work following the original injury, were you handicapped or in any way limited in performing your usual duties? (If yes, explain) ☐ Yes ☐ No

19. Describe fully your condition since you returned to work including all medical treatment received.

20. Describe the circumstances of the recurrence of disability. Explain why you believe your present condition is related to the original injury.

21. Describe all injuries and illnesses which you suffered between the date you returned to work following the original injury, and the date of recurrence. Arrange for the submission of all relevant medical records.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate provisions, be punished by a fine or imprisonment, or both.

I hereby claim medical treatment if needed, and up to 45 days Continuation of Pay and/or Compensation while disabled for work.

I certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge.

22. Signature of employee	23. Date (mo., day, year)

Part B - Employer

Official Supervisor's Report: Please complete information requested below

Supervisor's Report

24. Agency name and address of reporting office (include city, state, and zip code) | OWCP Agency Code 2550

Zip Code | OSHA Site Code

25. Employee's duty station (Street address and zip code) | 26. Date of first return to REGULAR duty following original injury. Mo. Day Yr.

Zip Code

27. Regular work hours From: : ☐ a.m. ☐ p.m. To: : ☐ a.m. ☐ p.m.

28. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

29. Date of injury Mo. Day Yr.

30. Date of recurrence Mo. Day Yr.

31. Date stopped work following recurrence Mo. Day Yr. Time : ☐ a.m. ☐ p.m.

32. Date pay stopped following recurrence Mo. Day Yr.

33. Date COP paid for recurrence From Mo. Day Yr. To

34. Date returned to work following recurrence Mo. Day Yr. Time : ☐ a.m. ☐ p.m.

35. Inclusive Dates Employee Received Leave Pay For Any Part of The Period Since Stopping Work

a. Annual Leave | b. Sick Leave | c. Other (Specify)

36. Pay Rate in Effect On:	a. Base pay	b. Subsistence	c. Quarters	d. Other Pay, i.e., Sunday premium or night differential
A. Date of Recurrence	$ per	$ per	$ per	$ per
B. Date Stopped Work following Recurrence	$ per	$ per	$ per	$ per

37. Did the employee receive medical care at an agency facility due to the recurrence? If so, please attach all relevant medical records. ☐ Yes ☐ No

38. At time of recurrence did official superior authorize medical treatment on form CA-16? ☐ Yes ☐ No

39. Following the original injury, did the employer make any accomodations or adjustments in the employee's regular duties due to injury related limitation? If yes, provide full details. ☐ Yes ☐ No

40. Please review the statements provided by the employee in response to Part A of this form and provide all relevant comments and additional information.

A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

41. Signature of official superior (at time of recurrence)	42. Title	43. Official superior's work phone number	44. Date (mo., day, year)

* U.S. GPO:1989-241-369/95858

Part C - Employee

(To be completed by the employee if not employed with the Federal Government at the time of a claimed recurrence of disability attributed to an occupational injury or illness sustained while Federally employed.)

1. For all jobs held since you left the job held when the initial injury occurred, list the full name and address of all employers, and the inclusive dates of all employment. Include any self-employment.

2. For all jobs listed in number 1 above, provide your job title, nature of duties performed, number of hours worked per week and rate of pay.

3. Describe all educational and/or vocational training received since your original injury. Include any licenses or certificates earned.

4. What was your rate of pay when you stopped work due to this recurrence of disability?

   $ _____ per _____

5. Do you claim compensation for lost wages? ☐ Yes ☐ No

   If yes, for what period _____ through _____ .

6. Have you received any pay during the period claimed? ☐ Yes ☐ No

   If yes, how much and from what source? _____

7. Claimant Signature	8. Date

INSTRUCTIONS FOR COMPLETING FORM CA-3 WHEN EMPLOYEE RETURNS TO WORK

PART - A

REQUIRED WRITTEN REPORT

- When disability ceases and/or employee returns to work, the official superior shall immediately report that fact to the OWCP on Form CA-3 unless this information has been previously submitted on Form CA-1 or CA-2 or otherwise. This form should be submitted for each injury resulting in time lost from work whether or not claim for compensation is made.

TELEPHONE/ TELEGRAPH REPORT

- If the employee is receiving disability compensation periodically each four weeks, the official superior should immediately telephone or telegraph the OWCP advising the date employee returned to work. This will avoid an overpayment of compensation. Follow-up should then be made with Form CA-3.

PAY RATE INFORMATION

- Employee's base pay in items 12a or 21a should not include value of subsistence, quarters or other pay. These should be shown separately in their own columns.

PART - B

CONTINUATION OF PAY

- In most traumatic injury cases, the employee will have qualified for and received continuation of pay under 5 USC 8118 (FECA). When this occurs, items 9, 13, and 15 in Part A will usually be left blank. When there is a continuation of pay, Part B must always be completed, unless the information has been submitted on Form CA-7, Claim for Compensation on Account of Traumatic Injury.

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Report of Termination of Disability and/or Payment

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Part - A General

1. Name of Injured Employee (last, first, middle)	2. Social Security Number	3. OWCP File Number (If known)

4. Department or Agency	5. Bureau or Office

6. Name and Address of Reporting Office (Include Zip Code)

7. Date and Hour of Injury (Mo., day, year)	8. Date and Hour Stopped Work (Mo., day, year)	9. Date and Hour Pay Stopped (Mo., day, year)	10. Date and Hour Returned to Work (Mo., day, year)
☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM

11. Employee's Work Week On Return To Duty If Other Than Monday Through Friday

S M T W T F S

12. Present Pay Rate If Different From That Received At Time Employee Stopped Work.

a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)

13. Inclusive Dates Employee Received Pay For Any Part of The Period of Absence Because of:

a. Annual Leave	b. Sick Leave	c. Other (Specify)
From: Through:	From: Through:	From: Through:

14. Has Employee's Work Assignment Been Changed Because of Disability Resulting From This Injury?

☐ Yes ☐ No If Yes, Describe The Type of Work Employee Is Performing.

15. If Interrupted, Show Dates Deductions For Health Benefits and/or Optional Insurance Were Resumed (Mo., day, year)	16. If Health Benefits Option Has Changed Since Disability Began, Show New Code Number and Date of Change (Mo., day, year)
Health Benefit _____ Optional Insurance _____	Number _____ Date _____

17. Remarks:

Part - B Continuation of Pay

18. Inclusive Dates That The Employee's Regular Pay Continued During The Period Of Disability. Do not include period of sick or annual leave (Mo., day, year)	19. Show The Gross Dollar Amount Of Regular Pay Which The Employee Received During The Period Of Disability. Do not include pay received for sick leave or annual leave.
From: Through:	- $

20. If Pay Rate Changed During The Period Employee Was Receiving Continuation Of Pay, Show The Date of Change (Mo., day, year)	21. If Pay Rate Changed During The Period Employee Was Receiving Continuation of Pay, Give New Rate			
	a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)

22. Signature of Supervisor	23. Title and Office Phone Number	24. Date (Mo., day, year)

DEATH BENEFITS FOR SURVIVING WIDOW, WIDOWER AND/OR CHILDREN UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT (FECA)

Widow or Widower	• To qualify for benefits, a widow or widower must have been living with the employee or separated for reasonable cause prior to the time of death. Payments continue for life or until remarriage. Upon remarriage, a widow or widower will receive a lump sum equal to 24 times his or her monthly compensation. If the remarriage occurs at age 60 or later, no lump sum is paid. Instead, payments continue for life.
Children	• Eligible children include natural, adopted, step and posthumous children unmarried and under 18 years of age. Payments continue beyond 18 if the child is incapable of self-support because of mental or physical incapacity. Payments also continue on behalf of children over 18 if they are full-time students. Student benefits terminate on: marriage, completion of four years of education beyond high school level, or at age 23, whichever occurs first.
Compensation Rates	• For widows or widowers - 50% of the employee's monthly pay if there are no surviving eligible children - 45% if there are eligible children. Children - 15% each, not to exceed a total of 30%, shared equally if there is a widow or widower; if there is no widow or widower, 40% for one child plus 15% for each additional child, shared equally. Monthly payments for all beneficiaries cannot exceed 75% of the employee's monthly pay rate, or 75% of the top step of GS-15 of the General Schedule.
Funeral/Burial Allowance	• Funeral and burial expenses up to a maximum of $800 may be paid. Amount paid by the VA will be deducted. If death occurs away from the employee's duty station, transportation costs may be paid to return the deceased employee to his home or last place of residence. In addition to any funeral or burial expenses, a sum of $200 may be paid for reimbursement of the costs of termination of the decedent's status as an employee of the United States.
Third Party Action	• If the injury or death results from activity of a person or party other than the Federal Government, a "third party action" or lawsuit may be indicated. In such instances the Department of Labor will provide further instructions.

If additional information is needed, it may be obtained from the Office of Workers' Compensation Programs.

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Stock No.

★U.S.GPO:1987-0-181-504/54846

INSTRUCTIONS FOR COMPLETING FORM CA-5, CLAIM FOR COMPENSATION BY WIDOW, WIDOWER, AND/OR CHILDREN

Who Should File Claim	• This claim form should be completed and filed by the widow or widower for self and surviving children. If there is no surviving widow or widower, the children's guardian completes the claim.
When Should Claim Be Filed	• Claim must be filed within three years following date of death, unless the decedent's immediate superior had actual knowledge of an on-the-job injury or death within 30 days; or written notice of the injury or death was given within 30 days. The timely filing of a disability claim will satisfy the time requirements for a death claim based on the same injury.
What Documents Are Required	• The marriage certificate(s) for a widow or widower; death certificate for decedent if not previously submitted; birth certificate or adoption documents for each child. Also, if appropriate, Letter of Guardianship. If either the decedent or the surviving spouse was previously married, legal documents showing dissolution of such prior marriage(s). Copies of certificates or documents are acceptable only if they are certified by the person having official custody of such records. They should then be attached to the claim form when it is filed.
How to Complete Claim	• All items should be completed. If an item is not applicable, indicate by showing "NA". Note that the form requests information about several different categories of persons, i.e., items 1-7 make inquiry about the decedent; 8-13 the surviving widow or widower; 14-14a, surviving children; and 15, the children's guardian. The attending physician's report on the reverse of the claim must also be completed before the form is submitted to the OWCP.
Funeral/Burial Allowance	• Submit original itemized funeral and burial bills. If paid, so indicate and give name and address of person making payment. If an Administrator or Executor has been appointed, give such person's name and address and attach a copy of the appointment document.

See the reverse of this page for a definition of dependents and a description of benefits.

Enclosure (6) to COMDTINST M12810.2

Claim for Compensation by Widow, Widower, and/or Children

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No. 1215-0155
Expires: 03-31-89

1. Name of deceased employee (Last, first, middle)	2. Date of Birth (Mo., day, year)	3. Date of Injury (Mo., day, year)	4. Date of Death (Mo., day, year)	5. Social Security Number
				___ ___ ____

6. Name and address of employing agency (Include zip code)	7. Nature of injury which caused death

Claim of Surviving Husband or Wife (Items 8 through 13)

8. Name and address (Include Zip Code)	9. Your Date of Birth (Mo., day, year)	10. Date of Marriage to Employee (Mo., day, year)

11. Were you living with the employee at time of death?	12. Were you ever married to anyone other than the employee?	13. Was employee ever married to anyone other than yourself?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

14. List all of employee's children from this marriage who may be entitled to compensation (See attached information sheet for definition of children):

Name	Relationship	Date of Birth	Address (Include Zip Code)

14a. List all of employee's children from prior marriages who may be entitled to compensation:

Name	Relationship	Date of Birth	Address (Include Zip Code)

15. If a legal guardian has been appointed for any child named above, give name of child, name and address of the guardian.

Child	Guardian	Guardian's Address (Include Zip Code)

16. List other relatives who were fully or partially dependent on employee:

Name	Relationship	Date of Birth	Address (Include Zip Code)

17. If employee was ever in the Armed Forces of the United States, give:	18. If application has been made for Veterans Administration (VA) benefits because of employee's death, give:
Service number: Branch of service: Period of service:	VA Claim number: Address of VA office where claim is filed:

19. If application has been made for U.S. Civil Service Annuity because of employee's death, give:	20. If a claim has been made against a third party because of employee's death, give:
CSF Claim Number: Date Annuity began: Amount paid per month: $_____	Amount of recovery: $_____ Name and address of third party:

21. Total burial expense	22. Amount of burial expense paid or payable by VA	23. Name and address of party (other than VA) whose funds were used to pay burial expense and amount paid:
$_____	$_____	$_____

I hereby certify that each and every statement made above is true to the best of my knowledge.

24. Signature of person filing claim	25. Address (Include Zip code)	26. Date (Mo., day, year)

Attending Physician's Report

1. Name of deceased employee (Last, first, middle)

2. Date of death (Mo., day, year)

3. What history of injury or employment related disease was given to you?

4. If treated for disease, give diagnosis.

5. If death was not instantaneous, describe the treatment you provided.

6. Show dates on which treatment was given.

7. What was the direct cause of death?

8. What were the contributory causes of death, if any?

9. In your opinion, was the death of the employee due to the injury as reported in item 3 above? Give the medical reasons for your opinion, unless causal relationship is obvious. ☐ Yes ☐ No

10. Was a biopsy or an autopsy performed?
If yes, give name and address of physician and arrange for a copy of the report to be submitted. ☐ Yes ☐ No

11. Name and address (Please type - include Zip Code)

12. Signature

13. Date signed (Mo., day, year)

DEATH BENEFITS FOR PARENTS, BROTHERS, SISTERS, GRANDPARENTS AND GRANDCHILDREN UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT (FECA)

Eligible Dependents	• Benefits are payable on behalf of partially or totally dependent parents, brothers, sisters, grandparents and grandchildren.
Period Of Entitlement	• Parents and grandparents: Payments continue until death, remarriage or termination of dependency. Minor brothers, sisters and grandchildren: Payments continue until death, marriage or attainment of 18 years of age. Payments may continue beyond 18 if the child is mentally or physically incapable of self-support or is a "full-time" student. Student benefits terminate on: marriage, completion of 4 years of education beyond high school level, or at age 23, whichever occurs first.
Compensation Rates	• For parent - 25% of the employee's monthly pay, if one is wholly dependent and the other is not dependent at all. If both are wholly dependent - 20% each. A proportionate amount is paid if either or both are partially dependent. Brothers, sisters, grandparents, and grandchildren - 20% if only one is wholly dependent. If more than one is wholly dependent - 30% shared equally. If one or more is partially dependent - 10% shared equally if more than one.
Payment Priorities	• Monthly payments for all beneficiaries cannot exceed 75% of the employee's monthly salary or 75% of the top step of GS-15 of the General Schedule. The surviving widow or widower and children have first priority. Other eligible dependents may receive payment only if the widow or widower and children's percentages are less than 75%.
Funeral/Burial Allowance	• Funeral and burial expense up to a maximum of $800 may be paid. Amount paid by the VA will be deducted. If death occurs away from the employee's duty station, transportation costs may be paid to return the deceased employee to his home or last place of residence. In addition to any funeral or burial expenses, a sum of $200 may be paid for reimbursement of the costs of termination of the decedent's status as an employee of the United States.
Third Party Action	• If the employee's death was caused by a person or party other than the Federal Government, a "third party action" or lawsuit may be indicated. In such instances the Department of Labor will provide further instructions.

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or have complied with the provisions of 20 CFR 10. (4) Furnishing all requested information will facilitate the claims adjudication process; and the effects of not providing all or any part of the requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION.

If additional information is needed, it may be obtained from the Office of Workers' Compensation Programs.

Form CA-5b
Rev. Sept. 1986

INSTRUCTIONS FOR COMPLETING FORM CA-5b, CLAIM FOR COMPENSATION BY PARENTS, BROTHERS, SISTERS, GRANDPARENTS OR GRANDCHILDREN

Who Should File Claim	This claim form should be completed and filed by the deceased employee's parents, grandparents or representative (custodian or guardian) of minor brothers, sisters or grandchildren. A separate form is required for each person claiming benefits.
When Should Claim Be Filed	Claim must be filed within three years following date of death, unless the decedent's immediate superior had actual knowledge of an on-the-job injury or death within 30 days; or written notice of the injury or death was given within 30 days. The timely filing of a disability claim will satisfy the time requirements for a death claim based on the same injury.
What Documents Are Required	The birth certificate of the deceased employee; also a death certificate if not previously submitted; birth certificates for minor brothers, sisters and grandchildren. If claim is made on behalf of a grandparent, birth certificate of decedent's mother or father, as appropriate. If claim is made on behalf of a grandchild, birth certificate of decedent's son or daughter as appropriate. Copies of certificates or documents are acceptable only if they are certified by the person having official custody of such records. They should then be attached to the claim form when it is filed.
How to Complete Claim	All items on the claim form should be completed. If an item is not applicable, indicate by showing "NA". Note that the claim form requests information about several categories of persons, i.e., items 1-7 make inquiry about the decedent; 8-20 the dependent; 21-25 the dependent's husband or wife, if married at the time of employee's death. The attending physician's report on the reverse of the form must also be completed before the form is submitted to the OWCP.
Funeral/Burial Allowance	Submit original itemized funeral and burial bills. If paid, so indicate and give name and address of person making payment. If an Administrator or Executor has been appointed, give such person's name and address and attach a copy of the appointment document.

See the reverse of this page for a definition of dependents and a description of benefits.

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Cat. No. L 7, Form CA-5b.

Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No. 1215-0155
Expires: 03-31-89

1. Name of deceased employee (Last, first, middle)	2. Date of Birth (Mo., day, year)	3. Date of Injury (Mo., day, year)	4. Date of Death (Mo., day, year)	5. Social Security Number

6. Name and address of employing agency (include zip code)	7. Nature of injury which caused death

8. Name of dependent (Last, first, middle)	9. Dependent's address (include zip code)	10. Dependent's birth date (Mo., day, year)

11. Dependent's Occupation	12. Dependent's Social Security Number	13. Dependent's relationship to employee	14. Extent of dependency on employee
			☐ Total ☐ Partial

15. Total amount employee contributed to dependent's support during 12 months immediately prior to death.	16. Did employee live with dependent during the 12 months immediately prior to death?	17. Total amount employee paid dependent in money or service for room and board in addition to amount shown in 15.	18. If no fixed amount was paid for room and board, what is the fair value of such room and board?
$ _____	☐ Yes ☐ No If "Yes", Complete 17 & 18.	$ _____ Per _____	$ _____ Per _____

19. If dependent was employed during 12 month period prior to employee's death, give:

Type of work performed:

Period of employment:

Monthly pay rate:

Name and address of employer:

20. Show dependent's income from all sources other than employment during 12 month period prior to employee's death:

Investments	$
Pensions	
Persons other than employee	
Other	_____
Total	$

Information about dependent's husband or wife (items 21 through 25)

21. Birth Date (Mo., day, year)	22. Occupation	23. Monthly pay rate	24. Total income from all sources for 12 months prior to employee's death.
		$ _____	$ _____

25. List all property owned by dependent and husband or wife (omit clothing, furniture, personal items).

Description	Date Acquired	Value

26. If employee was ever in the Armed Forces of the United States, give:

Service number:

Branch of service:

Period of service:

27. If an application has been made for Veterans Administration (VA) benefits because of employee's death, give:

VA Claim number:

Address of VA office where claim is filed:

28. If an application has been made for U.S. Civil Service Annuity because of employee's death, give:

CSF Claim Number:

Date Annuity began:

Amount paid per month: $ _____

29. If a claim has been made against a third party because of employee's death, give:

Amount of recovery: $ _____

Name and address of third party:

30. Total burial expense	31. Amount of burial expense paid or payable by VA	32. Name and address of party (other than VA) whose funds were used to pay burial expense and amount paid:
$ _____	$ _____	$ _____

I hereby certify that each and every statement made above is true to the best of my knowledge. Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.

33. Signature of person filing claim	34. Address (include Zip code)	35. Date (Mo., day, year)

Attending Physician's Report

1. Name of deceased employee (Last, first, middle)

2. Date of death (Mo., day, year)

3. What history of injury or employment related disease was given to you?

4. If treated for disease, give diagnosis.

5. If death was not instantaneous, describe the treatment you provided.

6. Show dates on which treatment was given.

7. What was the direct cause of death?

8. What were the contributory causes of death, if any?

9. In your opinion, was the death of the employee due to the injury as reported in item 3 above? Give the medical reasons for your opinion, unless causal relationship is obvious. ☐ Yes ☐ No

10. Was a biopsy or an autopsy performed? Arrange for a copy of the report to be submitted. ☐ Yes ☐ No

11. Name and address (Please type - include Zip Code)

I certify that all statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any knowingly false or misleading statement or concealment of material fact may subject me to felony criminal prosecution.

12. Signature

13. Date signed (Mo., day, year)

Instructions for Completing Form CA-6

When a Federal employee dies as a result of injury in performance of duty or because of an employment related disease, the death should be reported on this form. This form eliminates the need to complete and file the official superior's report on Form CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation or Form CA-2, Federal Employee's Notice of Occupational Disease and Claim for Compensation.

The form is to be completed by the deceased employee's official superior or other authorized official of the employing agency. It should be accompanied by a certified copy of the death certificate, when submitted to OWCP.

Form CA-5 or CA-5b should be supplied to the employee's spouse or next of kin.

If additional space is required, attach separate sheets and number the answers to correspond with the items on the form.

For additional information about death benefits, see 20 CFR 1.1 and/or Chapter 810, Injury Compensation, Federal Personnel Manual.

Box 22a (Occupation Code), Box 22b (Type Code), Box 22c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Recordkeeping and Reporting Guidelines.

OWCP Agency Code

This is a four digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

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*U.S.GPO:1987-0-181-504/54857

Enclosure (8) to COMDTINST M12810.2

Official Superior's Report of Employee's Death

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

1. Name of Deceased Employee (Last, first, middle)	2. Date of Birth (Mo., day, year)	3. ☐ Male ☐ Female	4. Social Security No.

5. Department or Agency	6. OWCP Agency Code	7. OSHA Site Code
	2550	

8. Name and Address of Reporting Office	9. Name and Office Phone Number of Employee's Official Superior

10. Date and Hour of Injury (Mo., day, year) ☐ AM ☐ PM	11. Date and Hour of Death (Mo., day, year) ☐ AM ☐ PM	12. Date and Hour Employee's Pay Stopped (Mo., day, year) ☐ AM ☐ PM

13. Describe how injury occurred	14. Was employee in performance of duty when injury occurred? ☐ Yes ☐ No (if No, explain):

15. Location where injury occurred	16. Location where death occurred	17. Immediate cause of death (Attach medical and autopsy report if available)

18. Employee's pay rate as of	a. Base pay	b. Subsistence	c. Quarters	d. Other
A. Date of injury	$ per	$ per	$ per	$ per
B. Date pay stopped	$ per	$ per	$ per	$ per

19. Did employee work in position held at time of injury for a full eleven months immediately prior to the injury? ☐ Yes ☐ No	20. If answer to 19 is no, would position have afforded employment for eleven months except for the injury? ☐ Yes ☐ No

21. Did employee receive leave pay for any part of period from time pay stopped to date of death? (Give inclusive dates) From To	22. a. Occupation code	b. Type code	c. Source code

23. Did employee receive continuation of pay (COP) during period prior to death? a. Pay rate used for COP $ per	b. Inclusive dates of COP From To	OWCP use - NOI code

24. If employee was enrolled in Health Benefit Plan for self and family, show HBS Code Number:	25. Show date through which HBS deductions were last made (Mo., day, year)	26. If employee received medical care prior to death, give name and address of attending physician

27. If injury was caused by a third party, give name and address of third party	28. Give name and address of the attorney representing the survivors if legal action is instituted against the third party	29. Show amount of third party recovery, if any $

30. If employee was a member of the Armed Services of the United States, show: Branch of Service: Serial No. (If known)	31. Has claim for survivor's benefits been filed with the Office of Personnel Management? ☐ Yes ☐ No

32. Name and address of employee's spouse or next of kin (Show relationship, if other than spouse)

33. Signature of Official Superior	34. Title	35. Date (Mo., day, year)

Form CA-6
Rev. Nov. 1986

INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not qualify for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

EMPLOYEE (or person acting on the employee's behalf) - Complete items 1 through 19 and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) - Complete items 20 through 37 and promptly forward the form to OWCP.

ITEM EXPLANATIONS - Some of the items on the form which may require further clarification are explained below:

Item Number	Explanation
4) Period of Wage Loss for which Compensation is Claimed	Enter inclusive dates covering the period for which you are claiming compensation. If intermittent periods are claimed, use a separate sheet to list each period individually.
5) Is This a Claim for a Schedule Award?	Schedule awards are paid for permanent impairment to a member or function of the body. A claim for a schedule award should not be made on the same form as a claim for compensation for wage loss; rather, a separate CA-7 should be used.
6) Has Any Pay Been Received for Period Shown in Item 4?	This question includes leave pay and COP received from the Federal job in which you were injured; and pay for work actually performed, whether at the Federal job in which you were injured or at other employment (including self-employment).
7) If Yes, Amount	Give the amount of pay received and the period for which it was paid. If there is more than one period, or more than one source of pay, explain fully on a separate sheet.
8) Was Claim Made Against 3rd Party?	A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.
13) List Your Dependents	Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he or she either lives with you or receives support payments from you, and he or she: 1) is under 18; or 2) is between 18 and 23 and is a full-time student; or 3) is incapable of self-support due to physical or mental disability.
21) If Employee Received Additional Pay, Identify Type and Show Amount	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.
28) Type and Inclusive Dates Employee Received Leave for Any Part of Period Since Stopping Work	Enter inclusive dates covering each period of leave. If leave was used for more than four individual periods, continue on a separate sheet. If leave was used for part of each day during a period, state how many hours were used per day; if the number of hours used per day varied, use a separate sheet to list each day.
29) Dates of Pay Continuation (COP) During Period of Disability	Enter the period of Continuation of Pay (see form CA-1 for a full explanation). If the injury was not a traumatic injury reported on form CA-1, this item does not apply.
30) Date All Pay Stopped	No compensation is payable for temporary total disability until the employee enters a non-pay status; therefore, item 30 refers to termination of all pay, including leave. Compensation is not payable for the first three days of disability after the end of any COP unless the disability exceeds 14 calendar days.

Enclosure (9) to COMDTINST M12810.2

Claim for Compensation On Account of Traumatic Injury or Occupational Disease

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee Statement

1. Name of Employee — Last / First / Middle
2. OWCP File Number
3. Social Security Number ___-___-____
4. Period of wage loss for which compensation is claimed — From mo. day yr. Thru mo. day yr. — Hours
5. Is this a claim for a schedule award? ☐ Yes ☐ No
6. Has any pay been received for period shown in item 4? ☐ Yes ☐ No
7. If yes, amount — From mo. day yr. Thru mo. day yr.
8. Was claim made against 3rd party? ☐ Yes ☐ No
9. Name of 3rd party or insurance carrier
10. Has the claim been settled? Give amount recovered.
Address
City / State / Zip
11. Have you ever applied for or received benefits from the Veterans Administration based on disability incurred while serving in the Armed Forces of the United States? ☐ Yes ☐ No If Yes, furnish ► — a. Claim number — b. Address of VA office where claim is filed — c. Nature of disability and monthly payment
12. Have you applied for or received an annuity under the U.S. Civil Service Retirement Act or any other Federal Retirement or Disability Law? ☐ Yes ☐ No If Yes, furnish ► — a. Claim number — b. Date annuity began mo. day yr. — c. Amount of monthly payment $

Dependents

13. List your dependents

Name	Date of Birth mo. day yr.	Relationship	Living with you? (yes/no)	Mailing Address, if different from your own

14. Support Information for above dependents
Are you making support payments for a dependent shown above? ☐ Yes ☐ No
15. Were support payments ordered by a court? If so, attach copy of court order. ☐ Yes ☐ No
16. If yes, support payments are made to: Last / First / Middle
Street
City / State / Zip
17. Amount / Per

Signature of Employee

18. I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed, and every statement above is true to the best of my knowledge and belief.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain compensation under the Federal Employees' Compensation Act, or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.

Employee's signature — Date (Mo., day, year)

19. Employee's home mailing address (Include Zip Code)
Street
City / State / Zip

Statement of Official Superior

20. Pay Rate As Of:	a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)
Date of Injury	$ per	$ per	$ per	$ per
Date Employee Stopped Work	$ per	$ per	$ per	$ per

21. If employee received additional pay, identify type and show amount

☐ Premium Pay | per | ☐ Night Pay | per |

☐ Sunday Pay | per | ☐ Other (Identify) | per |

22. Show work schedule for week pay stopped
☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

23. Did employee work in position for 11 months prior to injury? ☐ Yes ☐ No

24. If not, would position have afforded employment for 11 months but for the injury? ☐ Yes ☐ No

25. Total length of federal civilian service Yrs. Mos.

Health Benefits and Optional Life Insurance

26. Was the employee enrolled in a Health Benefits Program on the date pay stopped? ☐ Yes ☐ No

If yes, give code

Ending date of the pay period in which HBS / OLI Deductions were last made? mo. day yr.

27. Was the employee enrolled in an Optional Life Insurance Program on the date pay stopped? ☐ Yes ☐ No

If yes, was employee enrolled in Option ☐ A ☐ B ☐ C

If Option B, show number of multiples

Leave and Continuation of Pay

28. Type and inclusive dates employee received leave for any part of period since stopping work. Specify type of leave, SICK, ANNUAL, or OTHER

Type of Leave	From mo. day yr.	Thru mo. day yr.	Type of Leave	From mo. day yr.	Thru mo. day yr.
Type of Leave	From	Thru	Type of Leave	From	Thru

29. If employee received continuation of pay (COP), give dates.

30. Date all pay stopped mo. day yr. Hour : ☐ AM ☐ PM

31. Period for which compensation is claimed From mo. day yr. Thru mo. day yr.

Return to Duty

32. Date returned to work mo. day yr. Hour : ☐ AM ☐ PM

33. Work schedule when returned to work
☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

34. Did the work assignment change because of disability resulting from the injury? Describe. ☐ Yes ☐ No

35. Pay rate on return to work $ Per

Certification

36. A supervisor who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Signature of supervisor _____ Date _____

Supervisor's title _____

Agency name & address _____ Office phone _____

37. If OWCP needs specific pay information the person who should be contacted is ☐ Supervisor ☐ Other: Name Phone

Claim For Continuing Compensation
On Account Of Disability

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

STATEMENT OF INJURED EMPLOYEE – SEE INSTRUCTIONS ON REVERSE SIDE

1. NAME OF INJURED EMPLOYEE *(Last, first, middle)*	2. OWCP FILE NUMBER, IF KNOWN
3. HOME MAILING ADDRESS *(Include ZIP code)*	4. SOCIAL SECURITY NUMBER

5. DATE AND HOUR OF INJURY *(Mo., day, year)* ☐ AM ☐ PM	6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS *(Mo., day, year)* IF PAY LOSS WAS INTERMITTENT ATTACH SEPARATE SHEET SHOWING DATES AND HOURS OF PAY LOSS. FROM: THROUGH:

7. HAVE YOU RECEIVED ANY LEAVE PAY DURING THE PERIOD SHOWN IN ITEM 6? ☐ YES ☐ NO SHOW INCLUSIVE DATES. FROM: THROUGH: IF LEAVE USE WAS INTERMITTENT, ATTACH SEPARATE SHEET SHOWING DATES AND HOURS USED.	8. DO YOU WISH TO REPURCHASE LEAVE? ☐ YES ☐ NO

9. COMPLETE THIS ITEM IF YOU WORKED DURING THE PERIOD SHOWN IN ITEM 6. ATTACH A SEPARATE SHEET IF NEEDED.

a. SALARIED EMPLOYMENT.

DATES & HOURS WORKED	PAY RATE *(Per hour, day or week)*	TOTAL AMOUNT EARNED	TYPE WORK PERFORMED	NAME & ADDRESS OF EMPLOYER

b. COMMISSION AND SELF-EMPLOYMENT. *SHOW ALL ACTIVITIES, WHETHER OR NOT INCOME RESULTED FROM YOUR EFFORTS.*

DATES & HOURS WORKED	NAME AND ADDRESS OF BUSINESS	SELF-EMPLOYED ☐ COMMISSION ☐	TYPE OF ACTIVITY PERFORMED	INCOME DERIVED (ATTACH EXPLANATION IF NEEDED)

10. IF YOU HAVE APPLIED FOR EMPLOYMENT WITH THE U.S. TRAINING AND EMPLOYMENT SERVICE GIVE THE FOLLOWING:

REGISTRATION NO. DATE OF REGISTRATION OFFICE ADDRESS

11. IF YOU WERE ONLY PARTIALLY DISABLED AND DID NOT WORK, STATE REASON FOR NOT WORKING.

12. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED VA BENEFITS BASED ON MILITARY SERVICE FOR THE UNITED STATES, GIVE THE FOLLOWING:

CLAIM NO. NATURE OF DISABILITY AND MONTHLY PAYMENT NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED

13. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED AN ANNUITY UNDER THE CIVIL SERVICE RETIREMENT ACT OR OTHER FEDERAL RETIREMENT OR DISABILITY LAW, GIVE THE FOLLOWING:

CLAIM NO. AMOUNT OF MONTHLY PAYMENT NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED

14. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYEE'S BEHALF. Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.	15. DATE *(Mo., day, year)*

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STATEMENT OF OFFICIAL SUPERIOR

16. IF EMPLOYEE HAS RETURNED TO WORK, SHOW DATE AND HOUR *(Mo., day, year)* ☐ AM ☐ PM	17. SHOW EMPLOYEE'S WORK WEEK ON RETURN TO DUTY, IF OTHER THAN MONDAY THRU FRIDAY S M T W T F S
18. HAS EMPLOYEE RECEIVED ANY PAY FOR WORK, LEAVE, SUBSISTENCE, QUARTERS OR OTHER REMUNERATION FROM YOUR AGENCY DURING THE PERIOD SHOWN IN ITEM 6 ON THE REVERSE SIDE? ☐ YES ☐ NO	19. IF ANSWER TO ITEM 18 IS YES, SHOW: AMOUNT: $ TYPE OF PAYMENT: PERIOD: FROM: _____ THROUGH: _____

20. IF THERE HAS BEEN ANY CHANGE IN EMPLOYEE'S HEALTH BENEFIT ENROLLMENT AND/OR OPTIONAL INSURANCE SINCE PREVIOUS CLAIM FOR COMPENSATION WAS SUBMITTED, PLEASE EXPLAIN. *(i.e. change of plan or option; if additional deductions have been made by the agency, show amount and period.)*

21. REMARKS

22. SIGNATURE OF OFFICIAL SUPERIOR	23. TITLE	24. DATE *(mo., day, year)*

INSTRUCTIONS FOR INJURED EMPLOYEE

a. Items 1 through 15 on the reverse side should be completed by the injured employee or by someone acting on the employee's behalf. The form should then be given to the official superior.

b. The injured employee should file Form CA-8 each two weeks during the period of disability unless otherwise notified by OWCP. Forms may be obtained from OWCP or the employing agency.

c. Employees are advised that fraudulent claims are punishable by a fine of not more than $2,000, or imprisonment for not more than one year, or both.

INSTRUCTIONS FOR OFFICIAL SUPERIOR

a. The official superior must complete items 16 through 24 and forward the form to the appropriate OWCP office.

b. The official superior must also complete items 1 through 6 on Form CA-20a before sending that form to the attending physician. It will also be necessary for the official superior to show in item 3 on the reverse of the Form CA-20a, the address of the OWCP office to which the physician should send the completed form.

If additional space is required for any reply, a separate sheet of paper may be used, numbering the answers to correspond with items on the form.

NOTE: FAILURE TO SUBMIT THIS FORM PROPERLY COMPLETED WITH SUPPORTING MEDICAL EVIDENCE WILL DELAY PAYMENT OF COMPENSATION.

INSTRUCTIONS TO AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

SELECTION OF PHYSICIAN

- A Federal employee injured by accident while in the performance of duty has the initial right to select a physician of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 issued to either a United States medical officer/hospital or any duly qualified physician/hospital of the employee's choice.

  If the employee elects to be treated by a private physician, a copy of the American Medical Association standard billing form (AMA OP 407/408/409; OWCP-1500a) should be supplied together with Form CA-16.

  A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee.

  Generally, 25 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered.

PERIOD OF AUTHORIZATION

- Form CA-16 is valid for up to sixty days from date of issuance, and may be terminated earlier upon written notice from OWCP to the provider. It should not be used to authorize a change of physicians after the initial choice is exercised by the employee.

FEDERAL MEDICAL FACILITIES

- U.S. medical facilities include Public Health Service, Military, or VA hospitals. Federal health service facilities (health units) established under 5 USC 7901 are not U.S. medical facilities as used herein (see 20 CFR 10.400).

DEFINITION OF INJURY

- The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which requires medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP.

DEFINITION OF PHYSICIAN

- The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The reimbursable services of chiropractors under the FECA are limited by statute to physical examination, related laboratory tests and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

FORM COMPLETION

- Part A shall be completed in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in Item 1 and the signature of the authorizing official appears in Item 8. Check Box B1 or B2 or Item 6, whichever is appropriate. In case of illness or disease, only Box B2 may be checked.

  Show the address of the proper OWCP Office in Item 12. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

ADDITIONAL INFORMATION

- See 20 CFR 1 and/or Chapter 810, Federal Personnel Manual (FPM).

Information for Physician – See Reverse Side

INFORMATION FOR PHYSICIAN

YOUR AUTHORIZATION

- Please read Part A of Form CA-16. You are authorized to examine and provide treatment for the injury or disease described in Item 5, for a period of not more than 60 days from the date of issuance, subject to the conditions in Item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee. Authorization may be terminated earlier upon written notice from OWCP. For extension of the authorization to treat beyond the 60 day period, apply to the office shown in Part A, Item 12.

USE OF CONSULTANTS AND HOSPITALS

- You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accommodations unless a private room is medically necessary. Ancillary treatment may be provided to a hospitalized employee as necessary.

REPORTS

- After examination, complete items 14 through 38, of Part B, and send your report, together with any additional narrative or explanatory material, to the address listed in Part A, item 12. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA-17, "Duty Status Report" may be required by the employing agency during the first 45 days of disability. If disability continues beyond 45 days, monthly reports should be submitted. Reports from all consultants are also required. Delay in submitting medical reports may delay payment of benefits.

RELEASE OF RECORDS

- Injury reports are the official records of OWCP. They shall not be released to anyone nor may any other use be made of them without the approval of OWCP.

BILLING FOR SERVICES

- OWCP requires that charges be itemized using the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500, or HCFA-1500). Each procedure must be identified, in Column 24 C of the form, by the applicable Current Procedural Terminology (4th edition) Code (CPT 4). A copy of the form may be supplied by the employee at the time treatment is sought.

- Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

TAX IDENTIFICATION NUMBER

- The provider's Tax Identification Number (TIN) is an important identifier in the OWCP system. To speed processing and to reduce inaccuracy of payment, the provider's TIN (Employer Identification Number or SSN) should be shown on all reports and billings submitted to OWCP. If possible, providers should decide on a single TIN – either corporate or personal – which is used consistently on OWCP claims.

ADDITIONAL INFORMATION

- Contact the OWCP Office shown in Item 12 of Part A.

Please Remove These Instructions Before Submitting Your Report.

OMB No.: 1215-0103
Expires: 09-30-88

Authorization For Examination And/Or Treatment

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

The following request for information is authorized by law (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. A-108.

PART A – AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:

2. Employee's Name *(Last, first, middle)*	3. Date of Injury *(Mo., day, yr.)*	4. Occupation

5. Description of Injury or Disease:

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 11, subject to the condition stated in item A, and to the condition indicated either 1 or 2, in item B.

A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services.

B. ☐ 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.

☐ 2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide necessary conservative treatment if you believe the condition may be due to the injury or to the employment.

7. If a Disease or Illness is Involved, OWCP Approval for Issuing Authorization was Obtained from: *(Type Name and Title of OWCP Official)*	8. Signature of Authorizing Official:
	9. Name and Title of Authorizing Official: *(Type or print clearly)*
10. Local Employing Agency Telephone Number:	11. Date *(Mo., day, year)*
12. Send one copy of your report: *(Fill in remainder of address)* **U.S. DEPARTMENT OF LABOR** **Employment Standards Administration** **Office of Workers' Compensation Programs**	13. Name and Address of Employee's Place of Employment: Department or Agency Bureau or Office Local Address *(including Zip Code)*

Form CA-16
Rev. Oct. 1986

PART B – ATTENDING PHYSICIAN'S REPORT

14. Employee's Name *(Last, first, middle)*

15. What History of Injury or Disease Did Employee Give You?

16. Is There Any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? *(If yes, please describe)*
☐ Yes ☐ No

17. What Are Your Findings? *(Include results of X-rays, laboratory tests, etc.)*

18. What Is Your Diagnosis?

19. Do You Believe the Condition Found was Caused or Aggravated by the Employment Activity Described? *(Please explain your answer if there is doubt.)*
☐ Yes ☐ No

20. Did Injury Require Hospitalization? ☐ Yes ☐ No
If yes, date of admission *(Mo., day, year)*
Date of discharge *(Mo., day, year)*

21. Is Additional Hospitalization Required?
☐ Yes ☐ No

22. Surgery *(If any, describe type)*

23. Date Surgery Performed *(Mo., day, year)*

24. What *(Other)* Type of Treatment Did You Provide?

25. What Permanent Effects, If Any, Do You Anticipate?

26. Date of First Examination *(Mo., day, year)*

27. Date(s) of Treatment *(Mo., day, year)*

28. Date of Discharge From Treatment *(Mo., day, year)*

29. Period of Disability *(Mo., day, year) (If termination date unknown, so indicate)*
Total Disability: From To
Partial Disability: From To

30. Is Employee Able to Resume
☐ Light Work Date:
☐ Regular Work Date:

31. If Employee is Able to Resume Work, Has He/She Been Advised? ☐ Yes ☐ No If Yes, Furnish Date Advised

32. If Employee is Able to Resume Only Light Work, Indicate The Extent of Physical Limitations and the Type of Work That Could Reasonably be Performed with These Limitations.

33. General Remarks and Recommendations for Future Care, If Indicated. If You Have Made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.

34. Do You Specialize? ☐ Yes ☐ No *(If yes, state specialty)*

35. SIGNATURE OF PHYSICIAN. I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statment or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

36. Address *(No., Street, City, State, ZIP Code).*

37. Tax Identification Number

38. Date of Report

MEDICAL BILL: Charges for your services should be presented on the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.

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Duty Status Report

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

This request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical expenses may not be paid or may be subject to suspension under the Federal Employees' Compensation Program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

OMB No. 1215-0103
Expires: 9-30-88

Instructions for Completing and Submitting this Form

Supervisor: Complete Part A and refer the form to the attending physician for completion of Part B.

Attending Physician: Complete Part B. To prevent interruption of the employee's pay, the completed form should be returned to the employing agency (as shown in Item 12) within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in Item 11).

Part A - Supervisor

1. Name and Address of Medical Facility Providing Medical Services:

2. OWCP File Number (If known)

3. Employee's Name (Last, first, middle)

4. Date of Injury (Month, day, yr.)

5. Social Security No.

6. Occupation

7. Describe How the Injury Occurred and State Parts of the Body Affected.

8. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or Intermittently, and Give Number of Hours.

Activity	Continuous	Intermittent		Activity/Exposure	Continuous	Intermittent	
a. Lifting/Carrying: Sedentary 0-10 lbs.			Hrs Per Day	p. Fine Manipulation			Hrs Per Day
b. Lifting/Carrying: Light 10-20 lbs.			Hrs Per Day	q. Reaching above Shoulder			Hrs Per Day
c. Lifting/Carrying: Moderate 20-50 lbs.			Hrs Per Day	r. Heat			degrees F
d. Lifting/Carrying: Heavy 50-100 lbs.			Hrs Per Day	s. Cold			degrees F
e. Sitting			Hrs Per Day	t. Excess Humidity			Hrs Per Day
f. Standing			Hrs Per Day	u. Chemicals, Solvents, etc. (Identify)			Hrs Per Day
g. Walking			Hrs Per Day	v. Fumes (Identify			Hrs Per Day
h. Climbing Stairs			Hrs Per Day	w. Dust (Identify)			Hrs Per Day
i. Climbing Ladders			Hrs Per Day	x. Noise (Give dBA)			dBA Hrs Per Day
j. Kneeling			Hrs Per Day	y. Other (Describe)			Hrs Per Day
k. Bending			Hrs Per Day				
l. Stooping			Hrs Per Day				
m. Twisting			Hrs Per Day				
n. Pulling/Pushing			Hrs Per Day				
o. Simple Grasping			Hrs Per Day				

9. Does the Job Require Driving a Vehicle
☐ Yes (Specify) ☐ No
Operating Machinery?
☐ Yes (Specify) ☐ No

10. The Employee Works
Hours Per Day
Days Per Week

11. Send A Copy of This Report To:

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

12. Send the Original Report to (Name and Address of Employing Agency):

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Form CA-17
Rev. April 1987

Part B - Physician

13a. Does the History of Injury Given to You by the Employee Correspond to That Show in Item 7?

☐ Yes ☐ No (If not, describe)

13b. Description of Clinical Findings

13c. Diagnosis of Condition Due to Injury

13d. Diagnosis of Other Disabling Conditions

14. Is Employee Able to Perform His/Her Regular Work (Describe on the Front of This Form)?

☐ Yes, If So, ☐ Full-Time or ☐ Part-Time _____ Hours Per Day (Fill In)

☐ No, If not, complete item 15 below.

15. Complete the Following, If The Answer To item 14 is "No".

Activity	Continuous	Intermittent		Activity/Exposure	Continuous	Intermittent	
a. Lifting/Carrying: Sedentary 0-10 lbs.			Hrs Per Day	p. Fine Manipulation			Hrs Per Day
b. Lifting/Carrying: Light 10-20 lbs.			Hrs Per Day	q. Reaching above shoulder			Hrs Per Day
c. Lifting/Carrying: Moderate 20-50 lbs.			Hrs Per Day	r. Heat			degrees F
d. Lifting/Carrying: Heavy 50-100 lbs.			Hrs Per Day	s. Cold			degrees F
e. Sitting			Hrs Per Day	t. Excess Humidity			Hrs Per Day
f. Standing			Hrs Per Day	u. Chemicals, Solvents etc. (Identify)			Hrs Per Day
g. Walking			Hrs Per Day	v. Fumes (Identify			Hrs Per Day
h. Climbing Stairs			Hrs Per Day	w. Dust (Identify)			Hrs Per Day
i. Climbing Ladders			Hrs Per Day	x. Noise (Give dBA)			dBA Hrs Per Day
j. Kneeling			Hrs Per Day	y. Are Interpersonal Relations Affected Because of A Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.)			
k. Bending			Hrs Per Day				
l. Stooping			Hrs Per Day	☐ No ☐ Yes (Describe)			
m. Twisting			Hrs Per Day				
n. Pulling/Pushing			Hrs Per Day				
o. Simple Grasping			Hrs Per Day				

16. Describe Any Other Function of This Employee's Regular Work Which is Medically Restricted By The Injury.

17. Period of Disability (If termination date is unknown, so state)

Total Disability From To

Partial Disability From To

18. If Employee is Able to Resume Work, Has He/She Been Advised?

☐ Yes ☐ No

If Yes, Give Date of Advice _____

19. Date of Examination

20. Date of Next Appointment, If Scheduled

21. Typed or Printed Name and Address of Physician

22. Specialty

23. Tax Identification Number

24. Physician's Signature

25. Date

*U.S.GPO:1987-0-181-504/64352

FORM CA-20, PHYSICIAN'S REPORT

Compensation for wage loss cannot be paid unless medical evidence has been submitted supporting disability for work during the period claimed. For claims based on traumatic injury and reported on Form CA-1, the supervisor should detach Form CA-20, complete items 1-3 on the front, and print the OWCP district office address on the reverse. The form should be promptly referred to the attending physician for early completion. If the claim is for occupational disease, filed on Form CA-2, a medical report as described in the instructions accompanying that form is required in most cases. The supervisor should ensure that the employee has brought these requirements to the physician's attention. It may be necessary for the physician to provide a narrative medical report in place of or in addition to Form CA-20 to adequately explain and support the relationship of the disability to the employment.

For payment of a schedule award, the claimant must have a permanent loss or loss of function of one of the members of the body or organs enumerated in the regulations (20 C.F.R. 10.304). The attending physician must affirm that maximum medical improvement of the condition has been reached and should describe the functional loss and the resulting impairment in accordance with the American Medical Association **Guides to the Evaluation of Permanent Impairment.**

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or have complied with the provisions of 20 CFR 10. (4) Furnishing all requested information will facilitate the claims adjudication process; and the effects of not providing all or any part of the requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION.

IMPORTANT: A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION FOR LOSS OF WAGES OR PERMANENT DISABILITY CAN BE MADE TO THE EMPLOYEE.

IF YOU HAVE SUBMITTED A NARRATIVE MEDICAL REPORT OR A FORM CA-16 TO OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA 1500/OWCP-1500a.

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

1. COMPLETE THE ENTRIES 1-31 ON THE FORM; AND
2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 16; AND
3. SEND THE FORM AND YOUR BILL TO:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

For Sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

☆ U.S. GOVERNMENT PRINTING OFFICE 1987 - 181-506 - 415/54847

Attending Physician's Report

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Record of Examination

1. Patient's name Last	First	Middle	2. Date of injury mo. day yr.	3. OWCP File Number	OMB No. 1215-0155 Expires: 9-30-88

4. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe) ☐ Yes ☐ No — ICD-9 Code

5. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

6. What is your diagnosis? — ICD-9 Code

7. Do you believe the condition found was caused or aggravated by the employment activity described? (Please explain answer) ☐ Yes ☐ No

8. Did injury require hospitalization? If no, go to item #12 ☐ Yes ☐ No	9. Date of admission mo. day yr.	10. Date of discharge mo. day yr.	11. Additional Hospitalization required If Yes, describe in "Remarks" (Item 24) ☐ Yes ☐ No

12. What treatment did you provide?

13. Date of first examination mo. day yr.	14. Date(s) of treatment mo. day yr. mo. day yr. mo. day yr.	15. Date of discharge from treatment mo. day yr.

16. Period of total disability From mo. day yr. Thru mo. day yr.	17. Period of Partial Disability From mo. day yr. Thru mo. day yr.	18. Date employee able to resume light work mo. day yr.

19. Date employee is able to resume regular work mo. day yr.	20. Has employee been advised that he/she can return to work? ☐ Yes ☐ No	21. If yes, on what date was he/she advised? mo. day yr.

22. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #24 if necessary.)	23. Are any permanent effects expected as a result of this injury? If yes, describe in item #24. ☐ Yes ☐ No

24. Remarks

25. If you have referred the employee to another physician provide the following: Name	Specialty
Address	26. What was the reason for this referral?
City State Zip	☐ Consultation ☐ Treatment

Signature

27. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

Signature of Physician _____ Date _____

28. Name of Physician	29. Tax ID Number
Address	30. Do you specialize? ☐ Yes ☐ No
City State Zip	31. If yes, indicate specialty

INSTRUCTIONS FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

CERTIFICATION: BY SIGNING BLOCK 22 ON THE FRONT OF THIS FORM, THE PHYSICIAN CERTIFIES AS FOLLOWS:

I CERTIFY THAT ALL THE STATEMENTS IN RESPONSE TO THE QUESTIONS ASKED ON THIS FORM CA-20a ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPRESENTATION OR CONCEALMENT OF MATERIAL FACT, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

IMPORTANT: A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION CAN BE MADE TO THE EMPLOYEE.

IF YOU HAVE SUBMITTED A MEDICAL REPORT ON FORM CA-16, CA-20 OR A NARRATIVE REPORT TO THE OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20a.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA-1500/OWCP 1500a.

1. Complete the entries 7-23 on this report (and items 1-6 if not previously completed by the employing agency), and

2. Forward the report directly by mail to the OWCP office indicated below.

3.

OFFICE OF WORKERS' COMPENSATION PROGRAMS

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or have complied with the provisions of 20 CFR 10. (4) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).

* U.S. GOVERNMENT PRINTING OFFICE: 1986 - 181-504 - 413/54829

Attending Physician's Supplemental Report

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No. 1215-010-
Expires: 09-30-88

FOR INSTRUCTIONS SEE REVERSE SIDE

1. NAME OF INJURED EMPLOYEE *(Last, first, middle)*	2. OWCP FILE NUMBER, IF KNOWN
3. HOME MAILING ADDRESS *(Include ZIP code)*	4. SOCIAL SECURITY NUMBER
5. DATE AND HOUR OF INJURY *(Mo., day, year)* ☐ AM ☐ PM	6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS *(Mo., day, year)* FROM: THROUGH:

7. DATE OF MOST RECENT EXAMINATION *(Mo., day, year)*	8. IS EMPLOYEE'S PRESENT CONDITION DUE TO THE INJURY FOR WHICH COMPENSATION IS CLAIMED? ☐ YES ☐ NO	9. IS EMPLOYEE TOTALLY DISABLED FOR USUAL WORK? ☐ YES ☐ NO

10. DESCRIBE NATURE OF PRESENT IMPAIRMENT	11. STATE DIAGNOSIS
12. WHAT TREATMENT IS EMPLOYEE RECEIVING AND HOW OFTEN IS IT GIVEN?	
13. WHAT PERMANENT EFFECTS, IF ANY, ARE ANTICIPATED?	14. DESCRIBE ANY CONCURRENT DISABILITY EMPLOYEE HAS WHICH IS NOT RELATED TO THIS INJURY
15. WILL DISABILITY FOR REGULAR WORK CONTINUE FOR 90 DAYS OR LONGER? ☐ YES ☐ NO IF NO, APPROXIMATELY WHAT DATE WILL EMPLOYEE BE ABLE TO RETURN TO WORK? *(Mo., day, year)*	16. IF EMPLOYEE IS ABLE TO RESUME REGULAR WORK, HAS HE OR SHE BEEN ADVISED? ☐ YES ☐ NO IF YES, SHOW DATE EMPLOYEE WAS INFORMED *(Mo., day, year)*
17. IF EMPLOYEE IS ONLY PARTIALLY DISABLED, SHOW DATE HE OR SHE WAS ABLE TO PERFORM SOME WORK AND DESCRIBE SPECIFIC WORK RESTRICTIONS. *(I. e. limitations in stooping, bending, lifting, etc.)*	18. IF EMPLOYEE HAS BEEN REFERRED TO ANOTHER PHYSICIAN FOR CONSULTATION OR TREATMENT, GIVE PHYSICIAN'S NAME & ADDRESS.
19. RECOMMENDATIONS AND PROGNOSIS	
20. ADDRESS *(Include ZIP code)*	21. IF YOU SPECIALIZE, INDICATE SPECIALTY
22. SIGNATURE OF PHYSICIAN. I certify that the statements on the reverse apply to this report and are made a part hereof.	23. DATE OF REPORT *(Mo., day, year)*

Form CA-20a
Revised Oct. 1986

OMB No. 1215-0055
Expires: 09/30/90

Instructions for Completing the Attached AMA Uniform Health Insurance Claim Form (HCFA-1500) for FEDERAL EMPLOYEE'S COMPENSATION Claimants

GENERAL INFORMATION

Claims filed under the Federal Employees' Compensation Act (5 USC 8101 et seq.) are for employment-connected illness or injuries. All services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to give relief, reduce the degree or period of disability, or aid in lessening the amount of the monthly compensation, may be furnished.

"Physician" includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. The term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct subluxation as demonstrated by X-ray to exist.

FEES

OWCP is responsible for payment of all reasonable charges stemming from covered medical services to eligible claimants, and employs a relative value fee schedule and other tests to determine reasonableness. For specific information about any schedule limits which may apply to the services you are rendering, you may call the FEC District Office which services your area.

Your signature in item 25 of the claim form indicates your agreement to accept the Government's charge determination on covered services as payment in full, and your agreement not to seek reimbursement from the patient of any amounts not paid by OWCP as the result of the application of its fee schedule or related test for reasonableness. (Please also review carefully item 25 under the SPECIFIC INSTRUCTIONS below for other certifications approved by your signature on the form.)

Schedule limits are applied to procedures identified through an automated billing system, by code, corresponding to the AMA Physician's Current Procedural Terminology (CPT 4). Accordingly, you should familiarize yourself with that coding structure and enter the appropriate code for each service or procedure for which you are billing. Failure to identify the services rendered with the proper CPT 4 code may result in the rejection of the bill or the application of an incorrect unit value.

A separate line in Block 24 must be used for each procedure performed and billed.

SUBMISSION OF CLAIM

The form must be fully completed according to the instructions, and mailed to the appropriate Federal Employees' Compensation District Office. The bill may also be submitted to the employing federal agency, to be forwarded to the correct address.

For services rendered by a physician, chiropractor, or dentist, a medical report is required which indicates the dates of treatment, diagnosis, findings, and type of treatment offered. In the initial report, relationship of the injury or illness to the employment should be explained. X-ray or other test reports should accompany billings for these services.

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF INFORMATION

We are authorized by the Federal Employees' Compensation Act (5 USC 8101 et seq.) to ask you for information needed in the administration of this program. The information requested is used to identify you, determine your eligibility, and decide whether the services you received are covered by the FECA program. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service received or the amount charged would prevent payment of the claim. Failure to furnish other information, such as name or claim number, would delay payment.

SPECIFIC INSTRUCTIONS

The following instructions are keyed to the standard AMA/Health Care Financing Administration Claim form (HCFA -1500). Modified versions of this form issued by local Medicare/Medicaid intermediaries may also be submitted to FECA, if they have been approved by HCFA.

PATIENT INFORMATION:

Item 1. Enter the patient's last name, first name, middle initial.

Item 2. Enter month, day, and year of patient's birth.

Item 3. Omit.

Item 4. On one line, enter the street address, and the city, state and ZIP on another. Telephone number may be omitted.

Item 5. Self-explanatory.

Item 6. Enter Social Security Number of patient.

Item 7. Omit.

Item 8. Enter FECA Claim Number. This is generally a number prefixed with the letter "A". Omission of the FECA claim number will result in delays in bill-processing.

Item 9. List any potential third party payers other than FECA.

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Item 10. Check appropriate blocks.

Item 11. Omit.

Item 12. The signature of the patient or authorized representative authorizes release of the medical information necessary to process the claim, and requests payment. This must be completed for the bill to be considered.

Item 13. The signature of the patient or authorized representative authorizes payment of the provider identified in item 25. This must be completed for the provider to receive direct payment.

PHYSICIAN OR SUPPLIER INFORMATION:

Complete those items which are applicable to the service or equipment you are providing. Not all items will apply to a particular case.

Item 14. Enter date of first symptoms in the case of illness. Enter date of injury, in the case of trauma or accident.

Item 15. Enter the date the patient first consulted you or requested your services, for the condition for which the service is provided.

Item 16. If applicable, and you are the attending physician, your report should explain the previous occurrence and give dates.

Item 16a. Check this box only if the services were authorized by the employer on form CA-16, Authorization for Examination and/or Treatment.

Item 17. The attending physician should complete this item.

Item 18. The attending physician should complete this item.

Item 19. Complete this item when submitting this form for the first time for a given patient.

Item 20. Complete if applicable.

Item 21. Applies to services described in item 24.

Item 22. Complete if applicable.

Item 23. (A) Enter diagnosis, if known. The appropriate diagnosis code must be entered for each separate condition, using the coding structure of the International Classification of Diseases, Clinical Modification, 9th Edition (ICD 9 CM). These codes may be entered in item 23 or in item 24, Column D. The diagnosis must be included in a claim from a physician, dentist, nurse, chiropractor, or physicial therapist.

(B) Omit.

Item 24. In Column A, enter month, day, and year for each service rendered. Use a separate line for each distinct procedure. If several office or therapy visits are claimed, the date of each visit should be listed.

Column B should be completed using place of service codes on the reverse of the form.

Column C should fully describe the service that was rendered. To the left, the appropriate code from the Physician's Current Procedural Terminology, 4th Edition (CPT 4) must be entered. Do not use other codes, or make any other kind of entry in this space. See discussion under GENERAL INFORMATION above.

In Column D, enter the appropriate ICD 9 CM diagnosis code or the reference number from item 23 above.

In Column E, enter the charge for each procedure described.

If multiple units of the same procedure are provided on a single date, you may enter the number in Column F. Services provided on separate days must be listed on separate lines.

Column G may be omitted.

Item 25. The provider or a representative, must personally sign and date the claim form. The claim cannot be processed unless it is signed. By this signature, the provider certifies that the described services were in fact rendered as described, either personally or under direct personal supervision by the provider; that the foregoing information is true, accurate, and complete; further, that the services were medically necessary because of a condition indicated in item 23. In addition, the provider's signature indicates agreement to accept the Government's charge determination as payment in full for covered services (see the discussion of fee schedules under GENERAL INFORMATION above).

Item 26. Not applicable to the FECA program.

Item 27. Add all charges in item 24 Column E, and enter total.

Item 28. Enter the amount of any payment already received against the charges in item 24.

Item 29. Enter the amount due (item 27 less item 28).

Item 30. See item 33.

Item 31. Enter address to which payment should be sent. ZIP code is an identifying feature in our system, and must be included.

Item 32. (Optional) Enter your patient account number or other identifier for this bill (up to 15 characters).

Item 33. The Tax Identification Number is an important identifier on our automated system. If there is no firm or corporate Employer Identification number, the provider's Social Security Number should be entered. To speed processing and reduce inaccuracy of payment, providers who bill us frequently should, if possible, settle on a single Tax Identification Number - either corporate or personal - to be used on all OWCP claims. OWCP is required to advise the Internal Revenue Service of the identity of all providers of medical services and/or supplies receiving payments of $600.00 or more in a calendar year.

IF YOU DO NOT ENTER YOUR TAX IDENTIFICATION NUMBER, YOUR CLAIM CANNOT BE PROCESSED.

PLEASE DO NOT STAPLE IN THIS AREA →

[redacted]

FORM APPROVED
OMB NO. 0938-0008

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SSN) ☐ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
2. PATIENT'S DATE OF BIRTH
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NO
5. PATIENT'S SEX — MALE ☐ FEMALE ☐
6. INSURED'S I.D. NO (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)
7. PATIENT'S RELATIONSHIP TO INSURED — SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8. INSURED'S GROUP NO (OR GROUP NAME OR FECA CLAIM NO.) — ☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)
10. WAS CONDITION RELATED TO
   A. PATIENT'S EMPLOYMENT — YES ☐ NO ☐
   B. ACCIDENT — AUTO ☐ OTHER ☐
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NO
   11.a CHAMPUS SPONSOR'S STATUS — ☐ ACTIVE DUTY ☐ RETIRED ☐ DECEASED — BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW
   SIGNED DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
   SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
16.a IF EMERGENCY CHECK HERE ☐
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY FROM THROUGH
   DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3 ETC OR DX CODE
   1.
   2.
   3.
   4.
   B. EPSDT YES ☐ NO ☐ FAMILY PLANNING YES ☐ NO ☐
   PRIOR AUTHORIZATION NO

24 A DATE OF SERVICE FROM TO	B * PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G * T O S	H LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
   DATE
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ NO ☐
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO
31. PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS ZIP CODE AND TELEPHONE NO
32. YOUR PATIENT'S ACCOUNT NO
33. YOUR EMPLOYER I.D. NO
   I.D. NO

* PLACE OF SERVICE AND TYPE OF SERVICE (T O S.) CODES ON THE BACK
REMARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 SC (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured": i.e., items 3, 6, 7, 8, 9 and 11.

BLACK LUNG AND FECA CLAIMS: The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered a 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung related disorder

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422 510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and BLACK LUNG programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations or Federal agencies as necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workers' compensation will pay for treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles and coinsurance.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally rendered by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES:

- 1 - (IH) - Inpatient Hospital
- 2 - (OH) - Outpatient Hospital
- 3 - (O) - Doctor's Office
- 4 - (H) - Patient's Home
- 5 - - Day Care Facility (PSY)
- 6 - - Night Care Facility (PSY)
- 7 - (NH) - Nursing Home
- 8 - (SNF) - Skilled Nursing Facility
- 9 - - Ambulance
- 0 - (OL) - Other Locations
- A - (IL) - Independent Laboratory
- B - (ASC) - Ambulatory Surgical Center
- C - (RTC) - Residential Treatment Center
- D - (STF) - Specialized Treatment Facility
- E - (COR) - Comprehensive Outpatient Rehabilitation Facility
- F - (KDC) - Independent Kidney Disease Treatment Center

TYPE OF SERVICE CODES:

- 1 - Medical Care
- 2 - Surgery
- 3 - Consultation
- 4 - Diagnostic X-Ray
- 5 - Diagnostic Laboratory
- 6 - Radiation Therapy
- 7 - Anesthesia
- 8 - Assistance at Surgery
- 9 - Other Medical Service
- 0 - Blood or Packed Red Cells
- A - Used DME
- F - Ambulatory Surgical Center
- H - Hospice
- L - Renal Supplies in the Home
- M - Alternate Payment for Maintenance Dialysis
- N - Kidney Donor
- V - Pneumococcal Vaccine
- Y - Second Opinion on Elective Surgery
- Z - Third Opinion on Elective Surgery

Address List and Jurisdictional Map

FECA DISTRICT OFFICES

District Office 1—Boston
John F. Kennedy Building, Room 1800
Boston, MA 02203
FTS 835-2137
Commercial (617) 565-2137

District Office 2—New York
201 Varick Street, Room 750
P.O. Box 566
New York, NY 10014-0566
FTS 660-2075
Commercial (212) 337-2075

District Office 3—Philadelphia
Gateway Building, Room 15100
3535 Market Street
Philadelphia, PA 19104
FTS 596-1457
Commercial (215) 596-1457

District Office 6—Jacksonville
214 North Hogan St., Suite 1006
Jacksonville, FL 32202
FTS 946-2821
Commercial (904) 791-2821

District Office 9—Cleveland
1240 East Ninth Street, Room 851
Cleveland, OH 44199
FTS 942-3800
Commercial (216) 522-3800

District Office 10—Chicago
230 South Dearborn, 8th Floor
Chicago, IL 60604
FTS 353-1657, 5656
Commercial (312) 353-1657, 5656

District Office 11—Kansas City
1910 Federal Office Building
911 Walnut Street
Kansas City, MO 64106
FTS 867-2195
Commercial (816) 426-2195

District Office 12—Denver
1961 Stout Street
Drawer 3558
Denver, CO 80294
FTS 564-5407, 2627
Commercial (303) 844-5407, 2627

District Office 13—San Francisco
71 Stevenson Street, 2nd Floor
San Francisco, CA 94105
Mail: P.O. Box 3769
San Francisco, CA 94119-3769
FTS 484-6610
Commercial (415) 744-6610

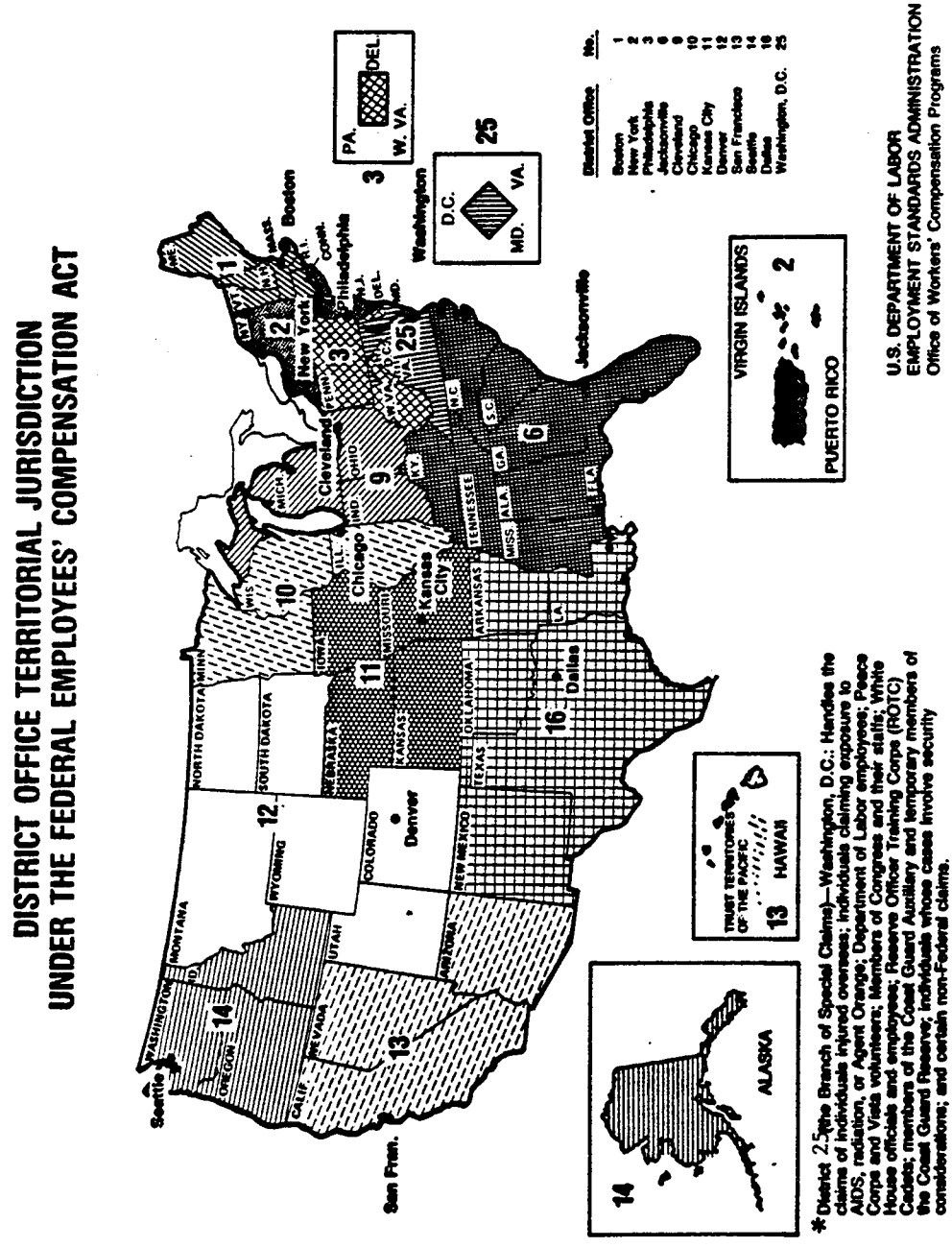
District Office 14—Seattle
1111 - 3rd Avenue
Suite 650
Seattle, WA 98101-3211
FTS 399-5508
Commercial (206) 442-5508

District Office 16—Dallas
525 Griffin Street, Room 100
Dallas, TX 75202
FTS 729-4707
Commercial (214) 767-4707

District Office 25—Washington, D.C.
1100 L Street, N.W., Room 9101
Washington, D.C. 20211
FTS 724-0713
Commercial (202) 724-0713

District Office 50—Special Claims
District 50 has merged with District 25.

Note: Jurisdiction for each district office is shown on the map on the following page.


DISTRICT OFFICE TERRITORIAL JURISDICTION
UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT
Seattle
San Fran.
Denver
Kansas City
Chicago
Cleveland
Boston
New York
Philadelphia
Washington
Jacksonville
Dallas
ALASKA
HAWAII
TRUST TERRITORIES OF THE PACIFIC
VIRGIN ISLANDS
PUERTO RICO
PA.
DEL.
W. VA.
D.C.
MD.
VA.
25
3
2
1
District
No.
Boston
1
New York
2
Philadelphia
3
Jacksonville
4
Cleveland
9
Chicago
10
Kansas City
11
Denver
12
San Francisco
13
Seattle
14
Dallas
16
Washington, D.C.
25
U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs
* District 25 The Branch of Special Claims)—Washington, D.C.: Handles the claims of individuals injured overseas; individuals claiming exposure to AIDS, radiation, or Agent Orange; Department of Labor employees; Peace Corps and Vista volunteers; Members of Congress and their staffs; White House officials and employees; Reserve Officer Training Corps (ROTC) Cadets; members of the Coast Guard Auxiliary and temporary members of the Coast Guard Reserve; individuals whose cases involve security considerations; and certain non-Federal claims.

Basic Forms for Processing

FORM NO.	FORM TITLE	PURPOSE	PREPARED BY	WHEN SUBMITTED	COMPLETED FORMS SENT TO
CA–1	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation	Notifies supervisor of a traumatic injury and serves as the report to OWCP when (1) the employee has sustained a traumatic injury which is likely to result in a medical charge against the compenstion fund; (2) the employee loses time from work on any day following the injury date, whether the time is charged to leave or to continuation of pay; (3) disability for work may subsequently occur; (4) permanent impairment appears likely; or (5) serious disfigurement of the face, head, or neck is likely to result.	Employee or someone acting on employee's behalf; witness (if any); supervisor	By employee within ♦ 30 ♦ days (but will meet statutory time requirements if filed no later than 3 years after the injury); by supervisor within ♦ 10 ♦ working days following receipt of the form from the employee.	Supervisor, by employee or someone acting on employee's behalf; then to the appropriate OWCP office by the supervisor.
CA–2	Federal Employee's Notice of Occupational Disease and Claim for Compensation	Notifies supervisor of an occupational disease and serves as the report to OWCP when (1) the disease is likely to result in medical charge against the compensation fund; (2) the employee loses time from work on any day because of the disease, whether the time is charged to leave or the employee chooses to claim injury compensation; (3) disability for work may subsequently occur; (4) permanent impairment appears likely; or (5) serious disfigurement of the face, head, or neck is likely to result.	Employee or someone acting on employee's behalf; witness (if any); supervisor	By employee within 30 days (but will meet statutory time requirements if filed no later than 3 years after the injury); by supervisor ♦ within 10 workdays ♦ after receipt of the form from the employee.	Supervisor, by employee or someone acting on employee's behalf; then to the appropriate OWCP office by the supervisor.

FORM NO.	FORM TITLE	PURPOSE	PREPARED BY	WHEN SUBMITTED	COMPLETED FORMS SENT TO
CA–2a	Notice of Employee's Recurrence of Disability and Claim for Pay/ Compensation	Notifies OWCP that an employee, after returning to work, is again disabled due to a prior injury or occupational disease. It also serves as a claim for continuation of pay or for compensation based on the recurrence of a previously reported disability.	Supervisor	Immediately upon receiving notice that the employee has suffered a recurrence. When the employee stops work as a result of recurring disability, the employee shall advise the supervisor whether he/she wishes to continue to receive regular pay provided qualifications are met or charge the absence to sick or annual leave.	Appropriate OWCP office.
CA–3	Report of Termination of Disability and/or Payment	Notifies OWCP that disability from injury has terminated and/or that continuation of pay has terminated and/or that employee has returned to work.	Supervisor	Immediately after the disability or continuation of pay terminates, or the employee returns to work.	Appropriate OWCP office.
CA–5	Claim for Compensation by Widow, Widower and/or Children	Claims compensation on behalf of these dependents when injury results in death.	Person claiming compensation (for self or on behalf of children) and attending physician.	Within 30 days, if possible, but not later than 3 years after death. If the death resulted from an injury for which a disability claim was timely filed, the time requirements for filing death claim have been met.	Supervisor, by claimant or someone acting on claimant's behalf; then to appropriate OWCP office.

FORM NO.	FORM TITLE	PURPOSE	PREPARED BY	WHEN SUBMITTED	COMPLETED FORMS SENT TO
CA–5b	Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren	Claims compensation for these dependents when injury results in death.	Person claiming compensation (or guardian on behalf of children) and attending physician	Within 30 days, if possible, but not later than 3 years after death. If the death resulted from an injury for which a disability claim was timely filed, the time requirements for filing death claim have been met.	Supervisor, by claimant or someone acting on claimant's behalf; then to appropriate OWCP office.
CA–6	Official Superior's Report of Employee's Death	Notifies OWCP of the employment-related death of an employee.	Supervisor	♦ Within 10 workdays after ♦ knowledge by supervisor of the employment-related death of an employee.	Appropriate OWCP office.
CA–7	Claim for Compensation on Account of Traumatic Injury or Occupational Disease	Claims compensation if (1) medical evidence shows disability is expected (and is not covered by COP in traumatic cases); (2) the injury has resulted in permanent impairment involving the total or partial loss, or loss of use, of certain parts of the body or serious disfigurement of the face, head or neck; (3) loss of wage-earning capacity has resulted.	Employee or someone acting on employee's behalf; supervisor, and attending physician (on attached Form CA–20)	In case of traumatic injury, the form must be completed and filed with OWCP not more than 5 working days before the termination of the 45 days. In case of occupational disease, this form should be submitted as soon as pay stops.	Supervisor, by employee or someone acting on employee's behalf; then to the appropriate OWCP office by the supervisor.

FORM NO.	FORM TITLE	PURPOSE	PREPARED BY	WHEN SUBMITTED	COMPLETED FORMS SENT TO
CA–8	Claim for Continuing Compensation on Account of Disability	Claims compensation when loss of pay continues beyond the time covered by the claim on Form CA–7.	Employee or someone acting on employee's behalf; supervisor, and attending physician (on attached Form CA–20a)	At least 5 days before the end of the period claimed on Form CA–7 or CA–8 for the period of disability supported by medical evidence.	Supervisor, by employee or someone acting on employee's behalf; then to the appropriate OWCP office by the supervisor.
CA–16	♦ Authorization ♦ for Examination and/or Treatment	Authorizes an injured employee to obtain examination and/or treatment for up to 60 days and provides OWCP with initial medical report. Treatment may be obtained from a local hospital or physician (who may be a surgeon, osteopath, podiatrist, dentist, clinical psychologist, optometrist, or, under certain circumstances, a chiropractor), or from a U.S. medical facility, if available. May also be used for illness or disease if prior approval is obtained from OWCP. The employee may initially select the medical provider of his/her choice but must request any change from OWCP.	Part A—Supervisor Part B—Attending Physician	Part A—By supervisor, in duplicate, within 48 hours followed first examination and/or treatment. Part B—By attending physician or medical facility as promptly as possible after initial examination.	Part A—Physician or medical facility. Part B—Appropriate OWCP office.
CA–17	Duty Status Report	In traumatic injury cases, provides supervisor and OWCP with interim medical report containing information as to employee's ability to return to any type of work.	Supervisor and attending physician	Promptly upon completion of examination or most recent treatment.	Original to the employing agency and copy to appropriate OWCP office.
CA–20	Attending Physicians Report	Provides medical support for claim and is attached to Form CA–7; provides OWCP with medical information.	♦ Attending ♦ physician	Promptly upon completion of examination or most recent treatment.	Appropriate OWCP office.

FORM NO.	FORM TITLE	PURPOSE	PREPARED BY	WHEN SUBMITTED	COMPLETED FORMS SENT TO
CA–20a	Attending Physician's Supplemental Report	Provides OWCP with additional medical information in connection with supplemental claim filed on attached Form CA–8.	♦ Attending ♦ physician	Promptly upon completion of examination or most recent treatment.	Appropriate OWCP office.
OWCP–1500a	Federal Employee's Compensation Program Medical Provider's Claim Form	Provides OWCP with standard billing form to facilitate payment of medical bills. The form should accompany the CA–16 when employee is referred to a physician.	Attending physician; employee must sign in item 12	Promptly upon completion of examination or treatment; physician may submit in usual billing cycle.	Appropriate OWCP office.

Injury/Illness Type and Source Codes

INJURY/ILLNESS TYPE

100 STRUCK
110 Struck by
111 Struck by falling object
120 Struck against

200 FELL, SLIPPED, TRIPPED
210 Fell on same level
220 Fell on different level
230 Slipped, tripped (no fall)

300 CAUGHT
310 Caught on
320 Caught in
330 Caught between

400 PUNCTURED, LACERATED
410 Punctured by
420 Cut by
430 Stung by
440 Bitten by

500 CONTACT
510 Contact with (motion of person)
511 Rubbed, abraded
520 Contact by (motion of object)

600 EXERTION
610 Lifted, strained by [single action]
620 Stressed by [repeated action]

700 EXPOSURE
710 Inhalation
720 Ingestion
730 Absorption

800 TRAVELING IN

999 UNCLASSIFIED OR INSUFFICIENT DATA

INJURY/ILLNESS SOURCE

0100 BUILDING OR WORKING AREA
0110 Walking/working surface (floor, street, curbs, porches)
0120 Stairs, steps
0130 Ladder
0140 Furniture, furnishings, Office equipment
0150 Boiler, pressure vessel
0160 Equipment layout (ergonomic)
0170 Windows, doors
0180 Electric, electricity

0200 ENVIRONMENTAL CONDITION
0210 Temperature extreme (indoor)
0220 Weather (ice, rain, heat, etc.)
0230 Fire, flame, smoke (not tobacco)
0240 Noise
0250 Radiation
0260 Light
0270 Ventilation
0271 Tobacco smoke
0280 Stress (emotional)
0290 Confined space

0300 MACHINE OR TOOL
0310 Hand tool (powered: Saw, grinder, etc.)
0320 Hand tool (non-powered)
0330 Mechanical power transmission apparatus
0340 Guard, shield (fixed, moveable, deadman)
0350 Video Display Terminal
0360 Pump, compressor, air pressure tool
0370 Heating equipment
0380 Welding equipment

0400 VEHICLE
0410 Privately-owned vehicle (includes rental)
0411 As driver
0412 As passenger
0420 Government-owned vehicle
0421 As driver
0422 As passenger

0430 Common carrier (airline, bus, etc.)
0440 Aircraft (not commercial scheduled)
0450 Boat, ship, barge

0500 MATERIAL HANDLING EQUIPMENT
0510 Earthmover (tractor, backhoe, etc.)
0520 Conveyor (for material and equipment)
0530 Elevator, escalator, personnel hoist
0540 Hoist, sling chain, jack (for material and equipment)
0550 Forklift, crane
0560 Handtrucks, dollies

0600 DUST, MIST, VAPOR, ETC.
0610 Dust (silica, coal, grain, cotton)
0620 Fibers
0621 Asbestos
0630 Gases
0631 Carbon monoxide
0640 Mist, steam, vapor, fume
0650 Particles (unidentified)

0700 CHEMICAL, PLASTIC, ETC.
0710 Chemical dry
0711 Corrosive
0712 Toxic
0713 Explosive
0714 Flammable
0720 Chemical liquid
0721 Corrosive
0722 Toxic
0723 Explosive
0724 Flammable
0730 Plastic
0740 Water
0750 Medicine

0800 INANIMATE OBJECT
0810 Box, barrel, container, etc.
0820 Paper
0830 Metal item, mineral
0831 Needle
0840 Glass
0850 Scrap, trash
0860 Wood
0870 Food
0880 Personal clothing, apparel, shoes

0900 ANIMATE OBJECT
0910 Animal
0911 Bite (dog)
0912 Bite (other)
0913 Disease
0920 Plant
0930 Insect
0940 Human (violence)
0950 Human (communicable disease)
0960 Bacteria, virus (not human contact)

1000 PERSONAL PROTECTIVE EQUIPMENT
1010 Protective clothing, shoes, glasses/goggles
1020 Respirator, mask
1021 Diving equipment
1030 Safety belt, harness
1040 Parachute

9999 UNCLASSIFIED OR INSUFFICIENT DATA

Note: Select most specific type and source for event which initiated injury/illness.
Use heading as "other" for that category.
Use TYPE as "verb" and SOURCE as "noun" to describe incident.
EX: Employee slipped on ice, cut hand on rock.
TYPE: 210 fell on same level
SOURCE: 0220 weather